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# **Consultation Skills in Veterinary Practice:**

exploring the links between consultation skills  
and key performance indicators.

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A project submitted to Middlesex University in partial fulfilment of the  
requirements for the degree of Doctor of Professional Studies.

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## **ABBREVIATIONS**

<b>AAHA</b>	American Animal Hospitals Association.
<b>AWBPL</b>	Accreditation of work based prior learning.
<b>BVA</b>	British Veterinary Association.
<b>BVHA</b>	British Veterinary Hospitals Association.
<b>CPD</b>	Continuing Professional Development.
<b>DABMDM</b>	Decision analysis based medical decision making.
<b>EBM</b>	Evidence based medicine.
<b>EQ</b>	Emotional intelligence.
<b>IIP</b>	Investor in People.
<b>MDX</b>	Middlesex University.
<b>MRCGP</b>	Membership of the Royal College of General Practitioners.
<b>MRCGP MAP</b>	MRCGP Membership by assessment of performance.
<b>NAVCA</b>	North American Veterinary Conference.
<b>NUVACS</b>	National unit for the veterinary advancement of communication skills.
<b>PGQVGP</b>	Post graduate qualification in veterinary general practice.
<b>RCGP</b>	Royal College of General Practitioners (Medical).
<b>RCVS</b>	Royal College of Veterinary Surgeons.
<b>SPVS</b>	Society of Practising Veterinary Surgeons.
<b>VBJ</b>	Veterinary Business Journal.
<b>VDS</b>	Veterinary Defence Society.
<b>Vet Record</b>	Veterinary Record.
<b>VPMA</b>	Veterinary Practice Management Association.

## **Executive summary.**

This project was part of a larger research project aimed at researching and supporting the development of a new postgraduate qualification in general veterinary practice. It arose in the beginning from the establishment of an MSc group of 8 experienced veterinary general practitioners in 2001, who researched various aspects of the question 'what are the postgraduate educational needs of the GP vet in the UK?' After completing the original work, 5 of the group continued their research into their Doctorates, and this project was the one in the subject of consultation skills.

The subject was very largely unexplored in the veterinary world, but extensive research had been done in the medical field. There were the challenges of formulating methods of collecting primary data in the veterinary field, and looking at the medical field to see if the methodologies were transferable.

The choice of methodologies was strongly influenced by fear factors, in which the researcher had to make choices based on what methods of data collection the veterinary practitioners accepted.

Research instruments were found and developed to explore aspects of the consultation. Key performance indicators were explored firstly separately, and then the research explored possible links between consultation skills and KPI's. Significant links were found, which lead to a greater understanding of the importance of consultation skills and how they might be analysed in ways that had potential for veterinary surgeons to see ways of identifying their skills and improving them.

The results were of high impact value.

## INTRODUCTION

The aim of this research project was to explore consultation skills and key performance indicators, and to see if there were any links between these which could be subjected to critical analysis, and utilised for learning and development of general practice services.

In today's world, there are different types of business, and these fall broadly into those in which the success of the business depends on the delivery of a product which requires no interface with the customer, and those which are heavily reliant on the success of the 'interaction between the service personnel and the clients'. Internet services or laboratory research done at a bench are examples of where there is little or no face to face or even telephone contact. People who use services, which have no personal contact and rely on price, can have a lack of appreciation of the skills, effort and costs involved in providing good personal service. The provision of this personal service is at the heart of consultation skills, which are critical to the delivery of a good veterinary or medical service.

There have been many changes in the veterinary profession over the past 30 years (Muckle, 2003). There have been huge changes in the type of work done by veterinary surgeons in practice from 50% farm animal : 50% small animal to 10% farm animal : 80% small animal. There have been huge advances in medicine and surgery, which have increased the capability of the veterinary profession to be able to do many more works to their patients and their clients. However, a key challenge has been the implementation and delivery of these services, and understanding the issues and changes in perceived values, which have developed alongside the technical developments. The environment and market in which the profession operates has also changed in how veterinary surgeons perceive themselves. They used to feel they were highly respected pillars of the community who, like the doctors (Svarstad, 1974), felt that if there was a problem it was the client's fault for not following their advice. Svarstad observed that there was a change beginning around the year 1974 in which



the doctors were starting to think that their patients did not always follow their advice for reasons which involved the communication abilities of the doctors themselves. This realisation has been much more recent in the veterinary profession, which has only introduced communication skills training in a very limited way into the veterinary undergraduate curriculum since 2000.

Tear Fund reports that today, 1/3<sup>rd</sup> of the world's population is infected with TB. This is a *Mycobacterium* that is understood, can be prevented and treated. Most of this problem is in the poorer countries of the world where they cannot afford the medicine. In the UK, it has been estimated that only 10% of the horse population is vaccinated against tetanus, a fatal but preventable disease. Both of these examples are illustrations of what many practitioners of medicine and veterinary medicine would consider 'less than ideal' or 'unsuccessful'. These are examples of the wider issues and issues of global strategy that affect the delivery of medicine and veterinary medicine. A key point of this research was to identify what veterinary surgeons consider to be 'successful consultations' and then find links between the skills needed to achieve those outcomes. There were environmental factors affecting the delivery of medicine through the consultations such as financial constraints, but an overall objective was to find ways of maximising the delivery of best practice through the use of good consultation skills. This could have an impact both in individual practices, and the much wider global distribution of medical and veterinary medical services.

Recently, the American Animal Hospital Association (AAHA) carried out a survey of compliance in conjunction with Hills Pet Nutrition. This survey found that 55% of compliance was lost in the consulting room.

The reasons why this happens in veterinary practice, and the processes which affect the compliance of the client in the consultation, is what this doctorate research is focussed on.

### ***The development of consultation skills in veterinary practice.***

The consultation in veterinary practice is typically only 10 minutes long (Gray & Cripps, 2005), and that is the window through which medicine is delivered, or failed to be delivered, so focussing on this time slot is very important for the clinician, the client and patient.

The development of the subject of consultation skills in the veterinary profession has started from a position of almost zero published literature in 2001, and very little training opportunity for veterinary surgeons. The medical profession has been developing their expertise and research for three decades, and has a useful pool of published evidence.

There are some critical issues affecting the development of the veterinary consultation in the UK:

- increasing client demands
- considerably increased financial and business pressures
- increasing demands to find ways of matching the training of veterinary surgeons to meet the needs of their clients
- there is a need to find ways of developing veterinary graduates' consultation skills fast enough to enable them to become a reasonably efficient practitioner within 6 to 12 months of qualifying or entering a new job in a general veterinary practice to meet the demands of the business

Over the past 30 years in the veterinary profession, typical key performance indicators (KPI's) have been quantitative measurements of gross turnover, net profit, average transaction value for each veterinary surgeon in the practice, numbers of vaccinations and other clinical procedures done in the practice and other measurements of the outcomes most obviously impacting on financial performance. There has been very little research into the links between KPI's and consultation skills. The Investor in People (IIP) standard was first introduced to the veterinary profession in about 1994,

and this started to recognise and introduce measurements of the processes involving the people in the business in a Kolb's Cycle of Learning; with planning, training, implementing skills, evaluating the outcomes and then going back to more planning. The profession had no real measurement or training in place for the consultations, which occupy a large percentage of both the professional time in delivery of service and the generation of revenue for the practice. It has become clear that quantitative analysis of the outcomes is only a part of the process of understanding and working on managing and improving the practice and service delivery.

### **Management of consultations.**

The assessment and management of consultations in clinical practice has been elusive and considered difficult for many years. One paper in the medical literature describes 'the most difficult aspect of practice to measure is the consultation, about which we have much to learn' (Ref: Howie, *et al* 2000).

*Quality management has to include qualitative analysis.* The analytical tools and methodologies that have been used in both veterinary and medical practice have left many questions unanswered. The purpose of this thesis is to explore these important questions further, and to produce some answers as well as some better questions from a better understanding of the whole picture.

There has been some debate about the importance of consultation skills in clinical practice. The proponents of the importance of them have a strong belief in the skills involved, whereas the 'devils' advocates' take the view that if it cannot be measured it is either not important or there is little that can be done to manage or improve it.

### ***Planning the approach to research in this project.***

There were some considerable challenges in researching these issues. In this research project, a careful selection of methodologies was made, with a view to exploring the use and application of a range of different instruments to measure consultation skills and the processes contained therein.

The planning process involved a period of about 18 months before the title was arrived at. This was because the subject matter in the field of consultation skills was enormous, whether or not the literature previously published had addressed some of the issues. Time spent free thinking to work out original ideas was needed to establish exactly what area I was going to focus on and how. The journey to finding the title involved consideration of the issues I was trying to define and methods and research instruments to find data which had a validity which would withstand considerable critique and scepticism from within the veterinary profession. Ideas were explored from a practical point of view and then literature search to find if confirmation of the ideas had been achieved previously, or if similar work would support this project. The methodology was studied critically before deciding on what data collection methods would provide evidence with a minimal level of bias.

The following approach was taken to the research design:

Collect data	Different methods, different boundaries
	of rationality and limitations of outcomes
	Literature Search
	Training/development Group
	Practice Visits : expanded discussions, Audiotapes, observations and interviews.

	Roadshow and Seminars : developing Methods of learning and producing reflections
Analysis	Commonality and definition of success
Conclusions	Informed analysis and assessment of consultations

## **Chapter 1. LITERATURE REVIEW.**

Interactions between human beings were first reported in the story of Adam and Eve. Consultation has developed with increasing sophistication and expectation over the years. The last 30-40 years can be summarised with reference to the following key research papers which highlight the developing eras in consultation skills.

- Svarstad, (1974). *Change from thinking 'Follow Doctor's orders' to 'Maybe it's the Doctors who have got the problem?'*
- Models : eg: Stott and Davis, (1979). *Each primary care consultation is an exceptional opportunity.*
- Tuckett, (1985). 'Meetings between experts'. *Sharing medical information.*
- Manning, (2003). *Consultation skills are important in veterinary practice.*
- Shaw, (2004). *Application of RIAS in veterinary practice.*
- Adams, (2006). *Reflection is an essential consultation skill.*

In the period preceding the 1970's, the patient was generally regarded as 'under doctor's orders' and if the patient did not follow those instructions, the patient was to blame. During the 1970's, Svarstad (1974) was one of the researchers who started to ask the question 'maybe the problem is partly that of the skills used by the medical practitioners in consulting?' Various models have been developed, and one that appeared to say something important was that of Stott and Davis (1979) who stated that 'every primary care consultation is an exceptional opportunity'. This and other models have been created and developed to explore the processes that lie within the consultation to make the most of the opportunity.

Tuckett (1985) described the concept that the consultation was a meeting between two experts, the clinician and the patient, both of whom had significant expertise to share with each other to make the most of that opportunity in the consultation.

Manning (2003) made it clear in an MSc thesis that consultation skills were important in veterinary practice, a point that was until only a few years previously barely given time in the veterinary profession and its education.

Shaw (2004) utilised a research instrument from the medical field and successfully transferred it to the veterinary field.

Adams (2006) found that reflection was a key consultation skill, and others have reported that consultation skills are essential clinical skills.

The veterinary profession was therefore in the early stages of development of research, which brought its own advantages in this project, and disadvantages. Advantages included the fact that this was very largely an un-researched area so there was plenty of research to do. The collection of primary data required a considerable effort in researching what was already known from the medical research and working on the possible transfer of usage of methodologies and instruments to the vet field. This was a fresh look at the whole subject, and the project did lend itself to offering a fresh look at the new veterinary field, but also a fresh look at what were found to be incompletely understood areas from the research in the medical field. Disadvantages included the challenge of producing original research in a wide open field. This was a unique opportunity but also a real challenge to produce some original solutions to some challenging questions that had a strong need of answers.

## **1A: The Science:**

### **1.A.1. Definition of a consultation.**

The Oxford English Dictionary definition of ‘consultation’ is ‘the action or process or formally consulting or discussing’. In the context of medical consultation, it is ‘a meeting with an expert or professional, such as a medical doctor, in order to seek advice’.

Some points on communication and consultation were written in the Bible:

**Proverbs 18 :**

- Verse 1: An unfriendly man pursues selfish ends : he defies all sound judgement.
- Verse 2: A fool finds no pleasure in understanding, but delights in airing his own opinions.
- Verse 13: He who answers before listening – that is his folly and his shame.
- Verse 21: The tongue has the power of life and death, and those who love it will eat its fruit.

**Proverbs 19:**

- Verse 20: Listen to advice and accept instruction, and in the end you will be wise.

These short verses written approximately 4000 years ago contain a lot of powerful wisdom. The deep understanding and incorporation of this wisdom into the behaviours of veterinary surgeons to achieve the essentials of good consultation skill were a driving force behind this research project. In many ways, these short verses express the simplicity of the skills involved, but the challenge of this research project was to gain a greater understanding of the processes involved.

**1.A.2. Significant articles.**

The initiation of this research presented several challenges, not least of which was deciding where to start. The broad title of ‘exploring links between KPI’s and consultation skills’ was chosen as a key area of interest and learning. Questions developed through searching the literature with a series of questions designed to produce papers with background, expertise and evidence of the available research.

Articles that were considered significant were those that were identified as likely to produce the most useful information to answer the research questions in this project.



Svarstad, (1974) worked in a medical practice with 8 doctors, each of whom had a team of support workers, and they were working in different clinics around a city but the drugs were dispensed from a central pharmacy. Svarstad observed behaviours in the doctor's consultations such as numbers of explanations given, and then interviewed patients a week afterwards to see how many tablets they had left. This methodology started to look at the question 'what skills did GP doctors have which could be linked to the number of tablets patients were prescribed and how many they actually took?' The observations of consultations were analysed with specific reference to the part pertaining to the physician's advice and recommendation for the medication. The conclusions were that the behaviours of the doctors in taking time to explain, listen, and elicit patient concerns were all highly influential on the outcome of compliance with their recommendations.

Svarstad was one of the first researchers to start to move away from the previously held assumption that all the problems the doctors had were to be found in the behaviours of the patients. This was a highly significant piece of research about a highly significant change in thinking in the development of consultation skills.

### **1.A.3. Definition of success.**

The articles that were chosen for study in some depth included a search for the meaning of success in a consultation. This was a critically important question, because without an understanding of this, it was not possible to understand what the clinicians were aiming at. In short, and in management jargon, 'if you can't measure it, you can't manage it'. There were many books on management of veterinary and medical practices, (Bower, *et al*; Opperman; Clarke; Mills & Roberston). Many numbers were included in definitions of 'key performance indicators' (KPI's) which can be measured, but the processes involved which affect the outcomes commonly measured in KPI's proved to be much more elusive.

The definition of success was the subject explored in the paper 'What is a successful doctor-patient interview? A study of interactions and outcomes' (Stewart, 1984). Opinions were sought as to what success was, and this was often found to be subjective. Stewart was one of the first to help the understanding of the validity of subjective analysis in respect to consultations using the 'Bales interaction process analysis' (Bales, 1950). This was a system of analysing the processes involved in the consultation. 12 categories of the Bales Interaction Analysis of the Process included:

1. Shows solidarity
2. Shows tension release
3. Agrees, shows passive acceptance, understands
4. Gives suggestion, direction
5. Gives opinion, evaluation, analysis, expresses feeling
6. Gives orientation, information, repeats, clarifies, confirms
7. Asks for orientation, information
8. Asks for opinion
9. Asks for suggestion, direction, possible ways of action
10. Disagrees
11. Shows tension, anxiety, asks for help
12. Shows antagonism, deflates other's self, defends or asserts self

This was actually a similar model of interaction analysis to the Roter Interaction Analysis System (RIAS) which was developed at a later date, and which had some more refinements. (Ref: Roter & Larson 2001; Roter & Larson 2002).

### **RIAS Coding Categories:**

#### Part 1 : Socioemotional exchange.

- Personal remarks, social conversation
- Laughs, tells jokes
- Shows approval – direct
- Gives compliment – general
- Shows agreement or understanding
- Back-channel responses
- Empathy
- Shows concern or worry
- Reassures, encourages or shows optimism
- Legitimises
- Partnership
- Self-disclosure
- Shows disapproval – direct
- Shows criticism – general

- Asks for reassurance.

Part 2 : Task-focussed exchange.

- Transition words
- Gives orientation, instructions
- Paraphrase/checks for understanding
- Bid for repetition
- Asks for understanding
- Asks for opinion
- Asks questions (close ended) medical condition
- Asks questions (close ended) therapeutic regimen
- Asks questions (close ended) lifestyle
- Asks questions (close ended) psychosocial-feelings
- Asks questions (close ended) other
- Asks questions (open ended) medical condition
- Asks questions (open ended) therapeutic regimen
- Asks questions (open ended) lifestyle
- Asks questions (open ended) psychosocial-feelings
- Asks questions (open ended) other
- Gives information – medical condition
- Gives information – therapeutic regimen
- Gives information –lifestyle
- Gives information – psychosocial
- Gives information – other
- Counsels or directs behaviour – lifestyle/psychosocial
- Requests for services or medication.

Part 3 : Global affect ratings.

- Adaptations of RIAS Coding System.
- Contextual Elaborations.
- Elaborations of topics of interest.
- Proficiency checklists.

Stewart, (1974) reported ‘the discipline of family medicine has espoused a patient-centred model of the doctor-patient interaction. Patient-centred interactions are those in which a patient’s point of view is actively sought by the physician. This implied that the physician behaved in a manner that facilitated the patient’s expressing himself and that, for his part, the patient speaks openly and asks questions. This exploratory study was undertaken to assess whether patient-centred interviews were related to positive outcomes’. The analysis was by interviewing patients some time after the

consultation to evaluate their satisfaction with care and the compliance achieved measured by tablet counts.

Stewart used a 14 point measurement of patient's satisfaction, and 3 points for the personal qualities of the physician. These were derived from the scale developed and shown reliable by Hulka & Zyzanski (1970), Zyzanski (1974), and validated by Stewart & Wanklin (1978). Part of the conclusion of this paper was that the extent to which the clinician asked about and explored the patient's concerns was related to the degree of patient compliance and understanding. This was an important finding because there were many articles in the literature, which fail to prove any real relationship between a definition of a successful consultation and the patient understanding and outcome.

#### **1.A.4. Searching the medical literature for a definition of quality in a consultation.**

Methods of recording and analysing consultation skills were the subject of many articles in the medical literature, which provided a rich source of information (Silverman & Kurtz, 1998)

In researching the practicalities of producing a meaningful analysis of the skills and the outcomes of the consultations, reference lists were requested from the Royal College of General Practitioners (RCGP) asking specific questions to explore how consultation skills could be analysed, related to outcomes and quality of care.

Howie *et al* (2000) reported that ‘disciplines achieve their identity through having their own case mix and the skills appropriate to that, by being able to support their own research and postgraduate training programmes, and by having a discernible philosophy. Defining targets for GP’s to aspire to implies statements about values and attitudes which reflect the philosophy of the discipline. This has proved the hardest component of general practice to define in a way that can be measured’.

**‘The core values of general practice include holism and patient-centredness. None of the measures of quality of care in general practice presently capture the expression of these values at routine consultations’.**

This was a statement of the conclusions in the year 2000, 16 years after Stewart (1984) had started to explore the definition of success in a consultation. This was an indication of both the strength of the pursuit of this challenge, and also the complexities involved.

Attempts have been made to design systems of analysing and measuring the quality of consultations (Maxwell *et al*, 2002). A Consultation Quality Index (CQI) may have a part to play in recognising poorly performing doctors, and also creating an incentive scheme to reward good consulting practice.

Howie *et al* (2000) paid particular attention to doctors new to practices, researching the effect of ‘how well patients know the doctor’ as a process measure, and on whether or not the patient was helped to cope with their illness ( ‘patient enablement’) as an outcome measure.

The research method was well designed, and included:

- A pre-consultation questionnaire for the patient exploring a variety of issue relating to health needs, and some questions about how well the patient knew the doctor. A simple Likert scale was used to gather the responses, recording the patient’s score of 1-5 of how well they knew their doctor.

- A questionnaire after the consultation asking about prescriptions and any interruptions experienced.
- The doctors recorded the start and finish time of the consultation to accurately record the total time of the consultation.

The aim of the analysis was to see if there was a relationship between a holistic approach, measured by how well the patient knew the doctor, and of understanding the patient needs and concerns. The patient enablement instrument (PEI) measured the patient's understanding of the prescription and whether or not they felt better able to cope with their illness. These were methods of developing an understanding of the processes within the consultation, and the methods were simple, not time consuming or intrusive, and were easily analysed. The drawback was that there were potentially a great many more components or aspects of different models of a consultation which were not taken into account.

Denley *et al* (2003) did a patient enablement survey in general medical practices, and found that practices which had the highest scores were related to the finding that the patients said 'they had enough time with their GP during the consultation'.

Tuckett *et al* (1985) took the view that the patient and the GP doctor were both experts in their own sphere, the patient because they were personally involved with their symptoms 24 hours a day, and the doctor because he/she had the medical knowledge to understand and analyse the symptoms. The book emphasised the concept of sharing medical information, and I have included this in my own personal definition of a successful consultation :

*'A successful consultation is one in which there is effective sharing of medical information which achieves the best outcome.'*

### **1.A.5. Assessment of consultation skills.**

McKinstry, B., *et al* (2004) attempted to research the question ‘Do patients and expert doctors agree on the assessment of consultation skills?’ This was pivotal to the assessment of the GP because there needed to be confirmation that the assessment of the GP doctor does reflect the patient’s understanding of what the doctor communicated. The methods that have been developed for assessment of the clinician’s consultation skills often seem to take no account of the patient/client understanding.

This paper was an excellent approach to the question of ‘how can an assessment of a consultation include both the medical expertise of the clinician and the understanding of the patient who is required to participate and carry out the instructions and treatments?’ Previous papers in the literature did not include the opinion of the patient. McKinstry *et al* concluded that there was a poor correlation between the results of assessment of the consultation by the method used by the RCGP, and the patient assessment of the consultation expressed in terms of the patient enablement instrument (PEI) and Consultation Satisfaction Questionnaire (CSQ).

Some of these points appear to have been omitted from the system used by the RCGP for a marking schedule with performance criteria, including:

- discover the reasons for a patient’s attendance
- define the clinical problem
- explain the problem to the patient
- address the patient’s problems
- make effective use of the consultation

The CSQ surveyed the patient by asking them to score:

- I am totally satisfied with my visit to my doctor.
- This doctor was very careful to check everything when examining me.
- I will follow the doctor’s advice because I think he/she is absolutely right.

The Patient Enablement Instrument (PEI) asked patients to score the results of the visit to their clinician as follows:

	Much better	Better	Same or less	Not applicable
Able to cope with life				
Able to understand your illness				
Able to cope with your illness				
Able to keep yourself healthy				

	Much more	More	Same or less	Not applicable
Confident about your health				
Able to help yourself				

Thus, McKinstry *et al* illustrated very clearly that the relationship between the use of consultation skills and the delivery of best practice through achievement of good patient understanding was likely to be complex and these methodologies did not necessarily provide a clear link between ‘clinician performance in consultation skill and outcome for the patient.’



With an open mind, there were different ways of evaluating consultations, and also different processes and outcomes to measure (Hutchinson & Fowler 1992; Hays 1990). The RCGP assessment was one system of evaluating the implementation of the processes involved in a consultation, developed from a review of previous research and also research by the RCGP. This has been used to evaluate aspects of different types of models (Campion, 2004). The following is the latest version of video assessment used by the RCGP.

**MRCGP Grid for assessing video submissions:**

	<b>CANDIDATE'S NUMBER:</b>	<b>and gender:</b>
<b>Tick if present</b>	<b>Performance Criteria</b>	
	1 Dr encourages patient's contribution	
	2 Dr responds to cues	<b>Merit</b>
	3 Dr elicits appropriate details to place complaint in soc & psych context *	
	4 Dr explores patient's health understanding	
	5 Dr obtains sufficient information for no serious condition to be missed *	
	6 Dr chooses an appropriate physical/medical examination to confirm or disprove hypotheses that could reasonably have been formed, or is designed to address a patient's concern	
	7 Dr makes clinically appropriate working diagnosis	
	8 Dr explains diagnosis, management, & effects of treatment	
	9 Dr's explanation takes account of patient's beliefs	<b>Merit</b>
	10 Dr specifically seeks patient's understanding of the diagnosis	<b>Merit</b>
	11 Dr uses appropriate management plan (reflecting modern, accepted practice)	
	12 Pt is given opportunity to be involved in significant management decisions *	
	13 In prescribing, the doctor takes steps to enhance concordance by exploring, and responding to the patient's understanding of the treatment	<b>Merit</b>
	14 Dr specifies conditions and interval for follow-up and review	

The patient enablement indicator attempted to evaluate the patient's added value from attending the consultation, but this could vary according to previous knowledge of the GP doctor and/or the prior medical knowledge and IQ of the patient for example. The consultation satisfaction questionnaire attempted to evaluate another aspect of the consultation in which there was an attempt to discover how the patient felt about the 'helpfulness and usefulness of the consultation to them personally.' There were numerous factors, which could affect how a patient felt about a consultation, and this could ideally be addressed by the GP doctor in empathising with the patient and sharing medical information sensitively and effectively. The RCGP system addressed many of these processes from the perspective of assessment of the doctor, but not from the perspective of the patient.

The analysis and assessment of the consultation should include analysis of both the processes and the clinical and satisfaction outcomes for the patient if a complete understanding of the relative success of the consultation is to be truthfully represented.

#### **1.A.6. Purpose of a consultation.**

The purpose of a consultation is to share medical information.

The benefits are hopefully that the needs of the client and the pet are met, and opportunities for education of the client and the vet are encouraged.

The outcome depends partly on what the focus of the consultation is.

Consultations are sometimes about the prevention of illness in healthy patients.

‘According to a recent consensus statement on physician-patient communication, (Simpson *et al* 1991), ‘effective communication between doctor and patient is a central clinical function that cannot be delegated.’ (Stewart, 1995).

‘The occasion when, in the intimacy of the consulting room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation.’ (Spence, 1960.)

## ***1.B: Models and definition of success.***

The definition of success could be related to an analysis of a model of the consultation, (such as the Calgary-Cambridge model: see appendix), although it seemed difficult to obtain a complete analysis using one model for every consultation. This was one of the reasons why the Royal College of General Practitioners (RCGP) ask candidates for their Membership by Assessment of Performance (MAP) to choose a selection of their videos of their consultations to illustrate particular points; which demonstrated their understanding and implementation of aspects of consultation technique across several different consultations. (Personal communication GP Doctor Andrew Sherley-Dale with reference to analysis of video consultations; University of Birmingham).

### **1.B.1. Summary of medical models.**

Dr Mei Ling Denney produced an excellent summary of the models used in the past 30 years (Appendix 9, which also has a reference list specific to these models). The models contain a working based on the following components of a consultation, and may include more than one of these:

- task
- process
- outcome
- skills
- understanding
- clinician/patient relationship
- patient's perspective of illness.

Byrne & Long (1976) described the process in terms of GP behaviours. RIAS tends to help analyse this (see analysis of audiotapes). Silverman's Calgary-Cambridge technique is a model with more details and analysis of the process with a focus on GP behaviour.

Pendleton *et al* (1984) took a step forward in developing the process by considering the outcomes and the effective use of time and resources in achieving this. This had a more rounded and holistic view of the consultation in which outcomes were considered as important or more important than the processes.

Neighbour (1987) used a system of checking critical points in the consultation (a method favoured by the RCVS Specialist in the visits to practices section of this thesis). This model aims to check each step of the process, asking at each point 'what next and how shall we get there?' It has the merit of checking understanding, which could be useful and important, but it may be too rigid for some clients who may not have a grasp of the problems involved in the illness, and therefore it could be overly dominated by the GP. It does help to focus on eliciting patient/client concerns, but summarising this could have the effect of closure of the consultation prematurely. Time pressures may produce this effect without the clinician realising what is happening, so an awareness of this in the clinician is important.

The Calgary-Cambridge (1996) approach is a detailed analysis of the process, which (as did Byrne) concentrates on GP behaviours. There was a tendency to assume that client concerns were successfully elicited and that patient/client understanding was achieved if the clinician demonstrated a series of prescribed behaviours. This could be useful for training purposes because the GP (and not the client) is usually the person being trained. Thus, this method can help the clinician to appreciate their own behaviours. The disadvantage from the practitioner's point of view could be that the model has no outcome measures. The practitioner and the decision maker for allocation of funding for research tends to need an appreciation of the outcomes in terms of clinical accuracy and patient/client satisfaction and understanding.

Each of these models has a value, but the choice of which one(s) to use depends on the purpose for which they are intended. The GP needs to be able to choose one or models to be aware of where they are in any one consultation, and to select the most useful and appropriate way forward. This will partly depend on the personality of the

GP, their style, and the problem they encounter during the consultation. Usherwood (1999) gives some useful general points on understanding the consultation.

An important set of skills is the ability of the GP to select appropriate skills during a consultation in order to make the most of it for the delivery of medical benefits for the patient. Stott & Davis (1979) had a particularly succinct and easily memorable system, based on the premise that there was exceptional potential in every primary care consultation, and the opportunities could be explored in four key areas : management of the presenting problems; modification of help-seeking behaviours; management of continuing problems; and opportunistic health promotion.

### **1.C: The veterinary literature.**

A survey carried out by the SPVS Masters Group through Veterinary Times in 2002 showed that all but 1 of the 903 respondents to the 9000 questionnaires thought that 'consultation skills were important to the GP vet.' The veterinary surgeons also placed communication skills second to clinical skills in their prioritisation of aspects of importance in the consultation. Client surveys have shown that clients place 'caring and communication' as top priority, with clinical skills second. Although it is said that clients tend to assume that the vet is highly competent clinically, they do not necessarily assume the vet is highly competent in communication and they make comparisons about different consulting skills between the veterinary surgeons they see.

Bronden, *et al* (2003), described a piece of work in which they analysed the responses of clients to the information they were given about the opportunities for chemotherapy for their pets. They found that clients were very positive about taking up the treatment when it had been explained fully to them. This illustrated an analysis of a certain specific type of consultation, namely for neoplastic disease. This was possible because at that particular clinic the cases seen were all of one type. In general practice, the types of cases seen vary enormously, and the design of questions to be included in the client questionnaire need to take account of this. It might be possible to group the types of consultation from general practice, and analyse them in groups to see if there are any common threads. For example, there are often cases involving vaccination, which could be grouped together to compare consultations with different veterinary surgeons and different practices.

Manning (2003) chose five questions for his interviews with veterinary surgeons and clients, and this seemed to be a good set of questions to analyse five main aspects of a general practice consultation. These were:

- what was the problem?
- did the vet give the diagnosis a name?
- what was the treatment?
- what was the prognosis?
- how well did you think the vet cared for you and your pet (score out of 5, with 5 being the highest)? Why did you think that?

These questions contain some probing into the process of the consultation, assessment of the transfer of information, and some assessment of the perception of the quality of the consultation by the vet and the client. This approach to the design of the questions was simple and effective in providing a good range of information, which could be analysed. The methodology did lack some detail compared to some other methods, eg: Bales interaction analysis, Miss-21 scale. (Ref: Meakin & Weinman (2002) 'The Medical Interview Satisfaction Scale adapted for British general practice.')

However, this simplicity had the advantages of lending itself to qualitative analysis through the use of pattern recognition in the responses, and in the audiotapes of the consultations. It is noted that although emphasis has been placed on the use of videotapes for analysis of consultations in medical practice, it seemed that it was the words that were the subject of the analysis rather more than the visual information including the nonverbal cues. (Ref: Turner & Edwards (1990).

The question of 'care' was the subject of two seminars given by Manning at the annual conference of Veterinary Christian Fellowship (VCF) 2005 (Manning, 2005). It did seem to be an umbrella term for all the components that make up the delivery of service, and it certainly was regarded very highly by clients.



### ***1.D: Models of the consultation in the veterinary literature.***

The National Unit for the Veterinary Advancement of Communication Skills (NUVACS) have taken as their foundation stone the Calgary-Cambridge technique of consultation (Silverman and Kurtz, 1998). It has 70 competencies, which can be summarised into 7 main ones.

- Greeting
- Building rapport
- History taking
- Clinical examination
- Explanation
- Treatment planning
- Closure

NUVACS have developed their own model of a consultation from applying the Calgary-Cambridge technique to veterinary practice, taking account of the important aspects of the practice environment supporting the consultation. The model has the advantages of simplicity in applying to veterinary practice. The model has been developed to include studies of how to deal with difficult clients, how to deal with bereavement, and other areas.

The NUVACS model was presented to a meeting of the British Small Animal Veterinary Association (BSAVA) in 2004 (see proceedings of the BSAVA 2004 Conference). The presenters (Carol Gray, Christine Magrath, Alan Radcliffe and Geoff Little) gave a description of their model, followed by a scenario of a consultation played by actors, and then the audience was asked to critique the scenario. The presenters had hoped that the model would be a useful reference for critique, which I believe it was. However, from my observations in the audience it seemed to me that I was not alone in thinking that the critique was an oversimplification of what was happening, and several delegates had intuitive and penetrating comments about the 'consultation scenario' that crossed over the boundaries drawn by the NUVACS model and went straight to the 'heart of the matter.' The experienced veterinary surgeons in the audience seemed to have a very

sound overview of the whole picture and were very able in analysing and reporting their findings, which they verbalised to the presenters in the interactive session.

Time and money are very important to private veterinary practice, because their sole income is from paying clients. Management books on veterinary practice have described the ideal consultation in terms of how well the client and the pet were looked after, and the process in the consultation in terms of 'delivery of care.' Ross Clarke (2005) gave a very good illustration of a successful consultation in his book (Taking your practice to the top'. Here are some extracts from Clarke's book which illustrate some of the thinking behind it:

“Ten-step exam room protocol to bond clients to your practice.

1. Present yourself as a medical professional.
2. Touch and talk to the client and the pet.
3. Do something medical.
4. Be an active listener.
5. Say something.
6. Show and tell.
7. Give something.
8. Complement clients about their pets : reinforce their decisions.
9. Give clients the best options first.
10. Close with... 'Have I answered all your questions?'

Seven steps to a higher recheck rate

1. Educate the client.
2. Establish a convenient day of the week for scheduling the recheck.
3. Choose a specific date.
4. Fill out an appointment card.
5. Ask your receptionist to schedule an appointment time.
6. Send a reminder card.
7. Make a reminder phone call.

### **Beyond the 10 steps and 7 steps.**

In addition to the 10 and 7 step programs outlined above, it's important to keep the following specifics about communication in mind:

#### **A. Rapport**

- Talk about the client's special interest
- Use the client's name
- Smile
- Be open and honest

#### **B. Empathy**

- Touch
- Pause
- Ask questions
- Be an active listener.”

These steps were the conclusions of the author from his experience, but the processes involved in reaching these conclusions was not well explained. Veterinary surgeons tended to prefer a clinical approach whereas managers and practice owners tend to prefer the financial management type of analysis. The veterinary surgeons had a duty of care to their clients and patients, and the managers/practice owners have responsibilities to their creditors and the payroll.

In the MSc thesis (Manning, 2003), the results of the focus group (the 5 other veterinary surgeons in the practice) included the following:

“What do YOU think are the most important things in a consultation?” The responses were:

- Relate to the animal – talk to and stroke the pet.
- Listen to the owner.
- Clinical expertise.
- Present the options – list the priorities and choices: use professional recommendation, guidance, cost calculations. Keep the initiative in the consultation. Discuss diagnostic aids.

- ‘Salesmanship’ – generally a disliked word in veterinary practice, but it produces a more positive response from veterinary surgeons if described as an opportunity to deliver more and better healthcare services for the animals.

### **1.E: Comparison of models of the consultation in medical and veterinary practice.**

The research behind the derivation of the Calgary Cambridge technique included a Delphi study (Holden & Wearne 2000; Cantrill *et al* 1996) to ascertain what doctors thought were the main competencies required of the GP, and this served to provide RCGP with the evidence base for the competencies in the framework for assessment of GP’s. No such study has been conducted by NUVACS who have adapted the medical model for use in veterinary practice.

Shaw *et al* (2004) stated in their discussion that ‘...we recognise that there are unique issues in veterinary medicine, such as the human-animal bond, the possibility of euthanasia, and the typical fee-for-service arrangement for payment. Because of these differences (between veterinary and human medicine), special studies are needed to address these issues....’

Key differences between NHS medical practice and private veterinary practice include:

- NHS is free whereas clients pay for the vet.
- NHS doctors have targets, and may be paid whether or not they see a patient frequently or not; whereas the income of the veterinary surgeon depends on seeing the clients.
- The animal is an important part of the consultation with the veterinary surgeon, but not with the doctor (usually).
- Time pressures are likely to vary between medical and veterinary practice.
- The level of training of the veterinary surgeon and the doctor in consultation and other ‘non-clinical subjects’ varies hugely. For example, after 5 years of working towards increasing the veterinary undergraduate training in communication skills since year 2000, the total average number of hours given to this subject in year 2005 at the UK veterinary schools is just 8. This compares to approximately 14 two hour sessions in the first year of medical school alone, which builds up in subsequent years. (Ref: SPVS Roadshow, Jan 2006, Dr Mei Ling Denney).

Care was needed when reviewing international literature, including from the USA, where in many situations the patients were expected to pay for their medical services direct to the doctors, and not to the State as in the UK.

These important differences may be significant when trying to adapt or use the medical model in veterinary practice. Failure to research the detailed background of the possible model for a consultation in veterinary practice could leave a lot to be desired.

There were key similarities between NHS medical practice and veterinary practice, which included:

- Medical information was being shared between a patient/client and a healthcare professional.
- The level of training of the healthcare professionals was similar in the clinical subjects.
- The client/patient was seeking help and care.
- The equipment, drugs and services being supplied were similar.

The medical model(s) aimed to achieve a good medical outcome. The ‘management model’ aimed to achieve an outcome of targets, which included client/patient satisfaction but was not so orientated towards accuracy of medical care in the language used to describe the model.

Consultation quality indices (CQI’s) have been developed but not very successfully (Robinson *et al* (2002)). Maxwell *et al* (2002) published a paper entitled ‘Acceptability of methods and measures used to determine quality of general practice consultations : results of a focus group study and an acceptability questionnaire.’

*‘General practitioner activity is increasingly under pressure to monitor its performance. The involvement of service users in the development and assessment of services is said to be a key feature of this process. This article reports on the acceptability among general practitioners of a patient-completed post-consultation*

*measure of outcome (the Patient Enablement Instrument (PEI), and its use in conjunction with two other indicators of quality, namely time spent in consultation and patients reporting knowing the doctor well.....these GP's were not comfortable with the concept of assessment of the clinical interaction by patients, and were anxious to link such assessment explicitly with clinical (disease-related) outcome.....'*

Clinicians tend to undervalue the relationship with their patients/clients, and in this paper the GP's seemed to need proof that a measurement of their interaction with patients had any effect on the clinical outcome. The appreciation of the relative importance of both the clinician and the patient/client in the interaction has been growing steadily through the literature over the past years since Svarstad in 1974 first suggested that perhaps the problems with the consultations were the doctors' and not their patients.

Maxwell's paper was also interesting because of similarities in veterinary practice. In veterinary practice, performance has been measured for many years by practice owners, and various pressures have been a source of challenge over as many years as veterinary practice has existed.

***1.F: No one effective and comprehensive model for the GP veterinary surgeon to develop his/her consultation skills.***

People are complex, and the interactions between them are even more complex and diverse. This seems to be a statement that few people would argue with. Therefore it is unlikely that any one model, or any one computer can either produce a perfect guide to a perfect consultation or to mimic one.

There are many outcomes from observations of consultations, which illustrate different aspects of consultations:

- models
- analyses
- ways of analysing words, phrases, interactions
- perceptions
- understanding

Silverman, D (2004), reported that the analyses were only as good as the coding used, and the skill and consistency of the observer/decoder, but the observation and interpretation of the analyses are powerful tools in describing ‘what is going on’ in the consultation. The ‘what is going on here’ is a classical qualitative analysis question.

The originators of the various models of a consultation (Silverman & Kurtz Calgary-Cambridge; NUVACS Veterinary Calgary-Cambridge model; Ross Clarke USA model;) all argue that the consultations can be analysed with reference to their models, and that each part of a consultation can be attributed to the presence or absence of a part of their particular model.

The Royal College of General Practitioners require GP doctors who are candidates for their membership exam to produce 10 critiques of a selection of their videoed consultations to illustrate various aspects of the skills they are using and thereby to demonstrate their competence in consultation skills. This was a good example of allowing flexibility in analysis and proving competence, requiring reflection, but also

it allowed the continual development of the system as new models and ideas developed.

Some analyses have been done of veterinary consultations by videotaping them and then analysing how many open and closed questions were used, average time to interruption of the client by the vet, and how many clients' and veterinary surgeons' perceptions of the main problem agreed or showed a mismatch. (Poster by Gray et al 2005). An attempt was also made to measure client satisfaction. The difficulty with this research poster was that there was really no link between the analysis of the consultation skills used by the veterinary surgeons and the perception or understanding of the client. There was an attempt to study some aspects of the use of the NUVACS model, and an attempt to analyse the consultations using the NUVACS model as a reference. There appeared to be no clear link between the application of the consultation skills observed and the outcome, which included client satisfaction. *One finding of possible significance was that in the consultations observed, open-ended questions were not used in 25%.* This could have an effect on whether or not a client's concerns were fully elicited. (Stewart *et al* 1979).

My conclusion is that **one way of analysis is not enough.**



### **1.F.1. The struggle with the qualitative analysis of ‘talk’.**

This is an important part of the interaction between the veterinary surgeon and the client in the consultation. It is also an area that veterinary surgeons, managers and staff tend to be very protective about and shy away from attempting to analyse through observations, partly because of a perceived threat from this analysis towards the veterinary surgeon, and partly because of an inability to analyse the process, and outcomes arising directly from it. This was why in my MSc thesis (Manning, 2003) the veterinary consultation was referred to as ‘the inner sanctum.’

Miles and Huberman (1994) recognised the struggle researchers have with these concepts. Qualitative analysis was perceived as attractive by some. This could be because of the wonderful descriptive material that arises from observation and/or ethnographic studies for example. The analysis of the material and presentation in documented form is difficult but not impossible. One important point is that qualitative analysis can provoke many questions and deep reasoning which challenge the researcher more than a set of figures or statistics which could be argued are the culmination at a set point in time of the qualitative analysis of a given scenario of ‘chaos’.

David Silverman is Emeritus Professor in Sociology at University College London. In his book, ‘Interpreting qualitative data: methods for analysing talk, text and interaction’, Silverman’s interest was in the interaction between the professional medical consultant and the patient.

The presence or absence of an accepted published literature in the form of textbooks appeared to be a very important reason behind the credibility of a subject for veterinary surgeons. Change has been occurring with substantial impact over the past 30 years (Muckle, 2003), but there has been little or no response in the veterinary literature until very recently in the area of consultation skills, (Manning, various references). The challenge of dealing with the ‘new issues’ for the veterinary

profession had some advantages because the ideas were so fresh and in many ways unfettered by previously published literature, but the disadvantage was that it was often an enlightened few who appreciated the importance of this subject.

Consideration of the reasoning behind the different possible research methods and instruments, their limitations, their advantages and practical applications, was the crux of this complex research. This was because whilst there were numerous models of a consultation, it appeared that they were not equally easy or possible to analyse. Some models were a more accurate reflection of a particular type of consultation, but were difficult to represent in simple analysis. Some consultation skills may require good reflection and presentation in essay format to facilitate a good critique. Other consultation skills may be more readily and reliably observed in a critique.

Shaw *et al* (2004) also discussed how they were concerned that their research of a randomised and small sample of veterinary surgeons and practices might not be transferable, but the methodology of using the Roter analysis system proved to be useful in analysing various aspects of the consultation:

- **Ratio of talk:** physician/client(patient).  
62% of the total conversation was contributed by the veterinary surgeon, with 54% directed towards the client and 8% towards the pet.
- **Question asking:**  
The least amount of conversation was dedicated to gathering data (9%). 69% of data gathering questions focussed on obtaining biomedical information, and 31% about the pet's daily activities. In general, 13 closed ended questions were used per appointment (range 0-42), compared with 2 open ended questions (range 2-11). In 25% of appointments, the veterinary surgeon did not use any open ended questions.
- **Information giving:**
- **Partnership building:** (including numbers of empathetic statements used by the veterinary surgeons).  
30% of the conversation was represented in this area. Expression of empathy which is known to build rapport, trust

and client and physician satisfaction was infrequent with only 7% of consultations showing the use of empathetic statements compared with 60% in some studies of medical practice (Bylund *et al* (2002)). This is a very important area because there is a large amount of evidence that clients value the caring the veterinary surgeon has and shows in the consultation (Manning MSc thesis 2003 client survey)

- **Rapport building:**

Shaw *et al* (2004) also commented that ‘An interactive approach is promoted in giving information, in contrast to direct transmission. With a direct transmission approach, the sender assumes that his or her responsibilities are complete once the message has been formulated and sent, whereas with an interactive approach, the interaction is considered complete only when the sender receives feedback about how the message was interpreted, whether it was understood and what impact it had on the receiver....’

An important point in the data gathering in this current project was considered to be that the principle of checking understanding can occur during the actual consultation, and in that case the interview of the client afterwards is probably of less value. Silverman *et al* (1999) recommended a ‘chunk and check method’ when giving information.

In assessing client understanding (Manning, 2003), the consultation technique needed to include more than a simple question such as ‘have you understood?’ because that was a closed question that invited a yes/no answer which may not actually have been correct. There was an issue of time management in this point, which meant that in order to check understanding, time must be made for this in the consultation. This was also an important point from the points of view of spending time interviewing the clients after consultations, and also it emphasised the need for the veterinary physician to include some open questioning of the client’s understanding.

It did appear that an analysis of the talk in the consultation may reveal more answers to the question of ‘how to analyse the client’s understanding of what the veterinary surgeon said.’

RIAS analyses voice tone and phrasing cues. Interviews of clients/patients after the consultation can help, but care was needed because bias was found to affect the consultation; eg: of ‘how well the client knew the clinician’ (Howie, 2000).

### **1.F.2. Does the type of consultation affect the type of analysis that can be used?**

Consideration was given to the hypothesis that different consultation types are likely to influence the choice that clinicians make in their approach, choice of words and most suitable models to follow, and that the outcomes are likely to be influenced by the clinician exercising wisdom in that choice.

There are many different types of consultation in general practice:

- Vaccination
- Routine health assessment
- Assessment for a repeat prescription
- Neoplasia,
- Dentistry
- Skin problems
- Neurological
- Gastrointestinal
- Heart
- Kidney
- Liver
- Pancreas
- Musculoskeletal
- Endocrine

Winefield (1995) asked the question : ‘Should different types of consultation be analysed differently?’

One of the problems in working in general practice was that the types of consultations cannot usually be significantly categorised and grouped to apply different methods of analysis, except between different clinics which have different management systems.

The technique of observing consultations and carrying out semi structured interviews with the clients and the veterinary surgeons afterwards was published by Manning (2004). The processes involved in veterinary nurse consultations were described in a new chapter (Manning, 2006)) in a new Veterinary Nursing textbook in April 2006. These publications illustrated and supported the application of the same method of analysis and use of research instruments in general veterinary practice, to the wide range of consultations in this workplace.

Many phrases and different uses of words have been identified, which help to transfer information and to elicit information from the client, different open and closed questions which help to find the accurate history. (Manning, 2006). RIAS and other analytical methods can be applied to different types of consultation, and has been encouraged by the establishment of a website for users of the technique to provide and exchange feedback on their experiences.

### **1.F.3. The politics and other pressures on the consultation.**

The original Society of Practising Veterinary Surgeons (SPVS) organisation was derived from difficulties practising veterinary surgeons were having with their paymaster (the Government) over work they did for the Ministry of Agriculture Fisheries and Food (MAFF) in 1933. The need to make a living and earn money to provide a financial framework to private veterinary practice has been very obvious for many years. Clients' opinions of the veterinary surgeon and the service have therefore been very significant for a long time, although the skills needed to engage in dialogue with the client taking money into consideration have not been emphasised in many training courses for veterinary surgeons. This may be partly due to the perceived clash of interests of the 'best interests for the animal' versus 'servicing the client within their budget.' The University Veterinary Schools have long considered that their courses have been full, with no room or priority for consultation skills. The medical schools have been developing consultation skills in their undergraduate curricula with a much greater priority and time allocation.

There have been ethical issues for both doctors and veterinary surgeons in managing time and money in consultations. It was interesting that pressures and demands on both the doctor and the veterinary surgeon have similarities in Society, and the ability of these healthcare professionals to present and deliver 'value for money' was being challenged in ways that in previous years (pre Svarstad, 1974) would have been accepted as 'doctor knows best.'

Hansard records many debates in the House of Commons in Westminster about the National Health Service. A session of Prime Minister's Questions in April 2005 leading up to the General Election recorded the Leader of the Opposition, Michael Howard, accusing the Prime Minister of fudging the target statistics which he had consistently failed to deliver, and also asked 'will the Prime Minister next be saying the Health service has the wrong sort of patients?'

The real threat to medical and veterinary practice seems to be the undervaluing of the care being provided, and the danger of a lack of acknowledgement and acceptance that the provision of that care takes time and money. The problems for the medical and veterinary practitioners involve addressing these issues and attempting to deliver a high standard of care within these constraints that Society imposes on them. Simultaneously, the healthcare professionals needed to promote what they believed to be, and could show, was good practice for the benefit of their patients and clients.

Therefore, it is important to establish what consultation skills are needed for the delivery of service to meet the client/patient needs. It is also important that links between consultation skills; and clinical, client satisfaction and financial outcomes are explored and more clearly illustrated.

The Pet Insurance Companies (PetPlan in particular) have produced statistics on the relationship between the percentage of insured clients a veterinary practice has, and the gross turnover in money per veterinary surgeon working in the practice. The amount of money was shown to rise with the number of insured clients, which tended to indicate that the removal of money issues from the consultation helped to increase the delivery of veterinary healthcare services.

#### **1.F.4. Constraints and issues in a consultation.**

‘Time management is the biggest problem that GP doctors have in their consultations, and when analysed, most problems that require training come down to time management in one way or another’ : Dr Chris Jenner, personal communication at the SPVS Clinical Audit Roadshow in January 2005.

The original Calgary-Cambridge technique and the NUVACS adapted model of consultations was a foundation stone, but there were more details in the processes involved, which together make up important competencies involved in the delivery of service. Good communication requires spontaneity and agility in both the delivery and response during the interaction.

The good practitioner needs to be able to choose the skills most appropriate to the circumstances in the consultation. Lack of training is a serious constraint for vets.

The design of veterinary practices has been given considerable attention by the British Veterinary Hospitals Association (BVHA), and the American Animal Hospitals Association (AAHA). The AAHA has published a book containing numerous examples of floor plans illustrating different choices of flow pattern for clients and animals in practices. Examples of floor plans are published every 2 months in the Veterinary Business Journal in the UK, where an article appeared on the design of the researcher’s practice (Manning, 2003).



## **1.G: Key Performance Indicators (KPI's).**

The title of this project is 'Exploring links between consultation skills and key performance indicators'.

### **1.G.1. Quantitative analysis.**

Success in veterinary practice management has included measurable parameters such as average transaction values per veterinary surgeon in the practice, personal gross turnover in pounds sterling per individual veterinary surgeon full time equivalent, numbers of clients per veterinary surgeon in the practice, number of appointments seen by each veterinary surgeon in the practice, and many more. These were commonly discussed in veterinary practice management symposia in the UK and USA (Ref: North American Veterinary Conference (NAVC).....Veterinary Practice management Association (VPMA)....Society of Practising Veterinary Surgeons (SPVS). Ref: BVA/Sainty (2003).

There are numerous analyses that are done in veterinary practice management in trying to establish some meaningful comparisons such as the SPVS/BVA annual practice survey, which had been running for about the past 20 years and included between 150 and 225 practices on average. There were also other surveys such as the MAI and Fort Dodge Indices, which were run in conjunction with Drug Companies supplying veterinary surgeries in the UK. The results of these surveys were the subject of presentations and publications from veterinary conferences, and they were a useful source of 'management information.'

McColl and others (1998) conclude that applying evidence from clinical trials is complex and challenging, and that overcoming operational issues and changing systems requires a multifaceted approach. There appears to be a serious attempt in the medical literature to explore the types of performance indicator and research whether or not they have a benefit for the health of the population. In the veterinary literature,

the papers tend to concentrate on financial indicators and numbers, which relate to the financial performance of the practice, but there are few attempts to find links between performance indicators and the health of the patients or the actual veterinary health service delivered. Moreau (2005) described practice financial indicators in the context of the 'health of the practice.' Moreau described the following financial indicators:

- gross revenue
- numbers of clients
- mean transaction value
- client loyalty (number of transactions per client)
- growth
- fixed costs
- variable costs
- profits
- costs of sales of retail products

Moreau also described indicators, which were used less conventionally in veterinary practice:

- Diagnostic ratio
- Vaccination ratio
- Hourly income per veterinary surgeon
- Client Surveys

The diagnostic ratio was the gross revenue of services (GRS), (excluding all over the counter sales and non medical revenues such as grooming or boarding), divided by the diagnostic services revenues (laboratory, ultrasound, radiology, endoscopy, etc). Moreau reported that in the USA it was preferable to keep this ratio under 5, because it was felt that a higher ratio might indicate that the veterinary surgeons were relying too much on empirical diagnostic methods.

The vaccination ration was the GRS divided by the vaccine consultation income. General practices, which had a high percentage of vaccinations were likely to be providing an inadequate range of clinical services. Moreau reported that in France, for an economically healthy practice, the vaccine associated services should be less than 20%.

Moreau's interpretation of performance indicators was of a typically distant nature from the actual delivery of medicine seen in the veterinary literature, and also from conferences in both the UK and the USA.

### **1.G.2. Qualitative analysis**

Scanlan (2006) described an approach to ‘building a quality healthcare engine that drives the practice and the staff’. Scanlan recognised that different clinicians had varying percentages of success in recommending dental treatments, and these could be linked to either a perception of the clinician that the treatment was too expensive and therefore there was a prejudging of the client’s perception, or the veterinary surgeon forgot to ask or was weak in the recommendation and postponed discussion of the vet’s preferred treatment to another time. The use of a computer programme with prompts to remind the veterinary surgeon to recommend an appropriate dental treatment was advocated. The emphasis was on ‘using a quality care engine as a *driving force*, but the links to motivation of employees, care of patients and client satisfaction were not discussed. The author referred to the use of reports to shed light on the processes, which might lead to an improvement of services.

The interpretation and implementation of the consultation skills needed to deliver good veterinary care has been found to be complex in the medical literature. Also, the patient centred consultation seems to be very important. Scanlan gave no evidence that implementing a computerised checklist could improve on the consistency of delivery of good medicine through a consultation.

Manning (2003) reported on the use of a checklist for a health assessment at the time of a vaccination, using a printed section of a card on which the assessment and the vaccination were recorded on the same line by the vet.

The question ‘does the use of certain tools such as checklists improve or reduce the number and effectiveness of consultation skills’ could be usefully explored.

The RCGP has devised a framework for the assessment of consultation skills of GP Doctors. This was an important point of reference for this project in devising ways of collecting the data from consultations in veterinary general practice, but also for

providing some thoughts on what observations might be the most critical and useful in the analysis.

The framework used in the Membership examination/MAP to evaluate competence in consulting skills was set out in the pages of the documentation of the Royal College of General Practitioners (RCGP).. This consisted of five broad areas:

- Discover the reason for the patient's attendance
- Define the clinical problem(s)
- Explain the problem(s) to the patient
- Address the patient's problem(s)
- Make effective use of the consultation

### **1.G.3. Defining success in assessment.**

The assessment used by the RCGP provides an analysis of the processes being used by the GP in the consultation, and it has been argued that there is a sound basis for this method as being a good and reliable method (Munro et al of the Panel of Examiners, 2005). However, McKinstry et al (2005) asked the question : ‘Is success in these examinations associated with practitioners’ attitudes and patient perceptions of the quality of the consultations?’ This paper concluded that there were no advantages perceived by patients in consultations with GP’s who had passed these examinations. Swanwick & Chana (2005) studied workplace assessment for licensing in general practice, and they found this to be of high validity. These authors concluded that there were 5 principles that should underpin workplace assessment:

- competency based
- developmental
- evidential
- locally assessed
- triangulated

McKinstry *et al* (2004) asked the question ‘Do patients and expert doctors agree on the assessment of consultation skills?’ This paper concluded that there was no meaningful association between the registrar’s score on the RCGP video examination and patient assessment either via the patient enablement instrument or the consultation satisfaction questionnaire. It could have been argued that there may be other methods of analysing clinician and patient assessment and perceptions of the consultation, but the important point was that the doctor and patient perceptions were different. Thus the MRCGP examination relied on an assessment of the process within the consultation, but it took no account of the analysis of the outcomes in terms of communications received by the patient, and so the method of assessment appears to be flawed on this important point.

Roter ([www/RIAS.org](http://www/RIAS.org)) has devised a method of analysing consultations using a list of categories of types of remarks, which can be identified by simple coding on listening to an audio or videotape. The codes have been designed to segregate remarks, but

sometimes the remarks fall into more than one category for an inexperienced coder. The coder does need some practice and familiarisation with the categories, but this can be learned relatively quickly. Roter suggests this might take 2 months, but it can be done in less time. Also, the principles of the system can be used in adaptations to different types of consultation in which specific types of remark are being researched. For example, types of medical comment in either the asking for information or giving information can be given a subcategory of 'diet or nutrition' to highlight remarks concerning this specific aspect of medical and therapeutic information shared during the consultation.

Roter & Larson (2002) described how the RIAS method for coding dialogue can be used and disseminated widely around the world in communication analysis.

Shaw *et al* (2004) described the application of the RIAS technique in analysing vet-client-patient communication in companion animal practice. The paper described the application of the system, and the results obtained. The results were described in broad terms as percentages of the categories used in the consultations, and the categories, which appeared to be underutilised or not used at all. A category was considered to be underutilised if the mean number of statements per consultation was less than 1. The scores for the number of statements made during each appointment ranged from 51 to 1420, with a mean number of 336.

Manning (2003) analysed the results of semi structured interviews carried out after the consultations by scoring whether or not the veterinary surgeon and the client understood each other and had the same perception of what was conveyed in the consultation about 5 different aspects (the problem, name of condition, treatment, prognosis, standard of care and why the care was judged to be of a standard). This produced a neat summary of the results and the ability to compare how much understanding was achieved in a given set of commonly used key points in a consultation. The results were presented in narrative description, tabulated and in graphical format which all contributed to quite a clear explanation of the findings.

Swanwick & Chana (2005) reported that the assessment of doctors by examination was inherently problematic. There were real differences between what doctors do in controlled assessment situations and their actual performance in real life situations. The SPVS Masters Group were well aware of this in their research ([www.vetgp.co.uk](http://www.vetgp.co.uk)) and in their recommendations to RCVS for a post graduate Certificate in general practice. Swanwick (2005) also reported that the Postgraduate Medical Education and Training Board (PMETB) included a statement in defining a satisfactory assessment system: 'Competence (can do) is necessary but not sufficient for performance (does do), and as experience increases, so performance-based assessment becomes more important.'

Analysis of consultations, (the skills, processes and outcomes), and the methods that can be used for analysis, are inextricably linked to the methods of assessment of the consultation. Analytical methods may help in the development of better systems of assessment and performance improvement.

A key question posed by this research project was:

#### **1.G.3.1. What do performance assessments look like, and how useful are they?**

What do they demonstrate, and what is their usefulness having identified an aspect of performance?

In setting a standard for performance assessment of doctor-patient communication in general practice, Hobma *et al* (2004) evaluated procedures and outcomes by applicability of the procedure, reliability of the standards, and credibility as perceived by the stakeholders who were identified as the GP doctors. It was interesting that the patients were not considered as stakeholders in this study carried out in the Netherlands. The assessment included videos of consultations, which were assessed by GP judges using the MAAS-global scoring system. This utilises a checklist of principally 3 sections : communication skills relevant to the specific phases of the consultation; general communication skills; and medical aspects. The first section included the introduction, points following on from a previous consultation (eg: naming previous illnesses and



establishing adherence to a management plan), requests for help, physical examination, diagnosis (including naming the diagnosis or working diagnosis and naming causes or the relations between findings and diagnosis, as well as prognosis), management (including shared decision making and asking for the patient's response), and evaluation of the consultation. This was tested using the Angoff method, and borderline regression method, which produced some statistical analysis, which in turn confirmed that this was a valid method of assessment. The GP doctors evaluated the relationship between the assessment of their consultation and their perception of it by using a simple Likert scale to place their answer to the single question 'did you completely agree to completely disagree with the assessment?' Limitations of the methods of assessment were identified, such as the need for several judges to compare results, and the cost of the assessment procedures. The credibility perceived by the GP doctors was high. The paper did suggest that further research was needed into the possibility of selecting other judges, such as patients.

Exploring links between consultation skills and KPI's is the title and the heart of this matter. Analytical methods and results may be linked more clearly and accurately to assessment of performance, Improvements in understanding these links through this research could have a powerful and useful impact for the development of consultation skills, and potentially the clinical outcomes and benefits arising from the consultation.

The papers in the literature, which have reported on aspects of consultation skills, such as Hobma (2004), have not analysed the clinical outcomes in terms of accuracy of the diagnosis or whether a panel of judges agreed with the working diagnosis or prognosis. This may be important if real links are to be found between consultation skills and clinical outcomes, but it is a very complex issue to research. Clinical audit may prove to be a useful way of providing some quality assurance to underpin the quality of the medicine being delivered, but further research is needed to develop this (Viner, 2003). The RCGP assessment does include aspects of clinical competence, but the assessment of the consultations tends to be a search for communication skills. There are possibilities for including some assessment of the clinical competencies in analysis of the

consultations, or to include reference to actual consultations in reflective essays. However, the paucity of literature on the links between consultation skills and actual clinical competence and outcomes indicate that this is an area that has not yet been researched. Some key performance indicators have been argued as indicating some aspects of clinical performance in the veterinary literature (Moreau). Stewart found that patient centred-ness was linked to eliciting patient concerns. This research project aims to explore more ways of finding links between consultation skills and KPI's.

Munroe *et al* (2005) investigated the reliability of written tests in the MRCGP examination, and they reported that the reliability was good in terms of assessment of the processes involved in the consultation, and the GP's appreciation of them. The validity of the RCGP method has been investigated by McKinstry *et al* (2005), who found that there was no link between patient enablement score (PEI) and possession of the MRCGP. This tends to confirm that evidence is required from the patients/clients to triangulate the evidence obtained from assessments of the GP's understanding of the processes. The delivery of the medicine is dependent on the patient/client understanding, agreement and compliance with the GP's explanation and instructions, and so this cannot be removed from a holistic analysis of the consultation.

#### **1.G.3.2. What has been done so far to address these issues?**

The first reference considered very seriously in this research was the MSc thesis (Manning, 2003), which was groundbreaking work, taking the concepts of consultation skills and looking at them in general practice. This was very useful because it illustrated some opportunities, obstacles and benefits of researching consultation skills in veterinary practice.

NUVACS was almost the only other source of information in the veterinary field. Gray (2003) reported on the establishment of NUVACS (National Unit for the

Advancement of Veterinary Communication Skills)) as a joint project between the RCVS, the Veterinary Defence Society (VDS) and the veterinary schools in the UK and Ireland. They have been partly funded by the Veterinary Defence Society, which has identified for many years that more than 80% of the claims against veterinary surgeons arise from the area of communication. The establishment of communications training in the University Veterinary Schools as a result of this work, starting at Liverpool, which is geographically close to the HQ of the VDS, has been a significant step forward. The work has been mainly directed at undergraduates, although the VDS has run postgraduate reunions for several years in which they also discuss communication issues. Recently, a CDRom has been produced for sale to practices, which takes the form of a workshop for viewers to observe actors in consultations and show how consultations might result in poor experiences.

It was my view for some years that there had been too much of a negative emphasis from the VDS in their message, which has been received as 'you are likely to be sued in your first year after graduation.' This message has been altered in the past two years to a more positive stance, which has been more encouraging. However, the graduates who I have seen and spoken to have mainly seen the role of actors as amusing, not relevant to them, and have not taken the message very seriously. The other point that some graduates have made is that they feel they know who in their class cannot communicate well and those who can; but they say they do not expect training can make the poor communicators better or significantly alter the communication skills of the graduates who are better in this field.

Mellanby & Herrtage (2004) surveyed the mistakes made by recent veterinary graduates, and found that there was a considerable negative effect on the clinicians of making a mistake. However, the paper concentrated on the clinical aspects of the work such as incorrect interpretation of a diagnostic test or radiograph, mistakes during sedation, anaesthesia, surgery or euthanasia. The research did not address the problems arising from communication in practice, but it did highlight the need to

research the ways of handling mistakes for the benefit of patients and clinicians. References were given to suicide in practice.

Research has been done at the Cambridge Veterinary School (Latham, 2004-5, as yet unpublished), to investigate whether training of students in communication skills actually made any difference to the outcomes. The results showed that students who received no training produced significantly poorer results than those achieved by students who received some training. The best results were achieved by students with the most and best form of training.

The Society of Practising Veterinary Surgeons (SPVS) has been active in the field of communications for many years, and has run the Final Year Students Seminar at Lancaster University in September for about the past 15 years, under the wing of the SPVS Educational Trust, the RCVS Educational Trust and the British Veterinary Association. A main theme of this seminar has been communication, and the VDS have been a provider of CPD for many years. Manning (1998) described the challenges for veterinary graduates and the practices employing them of addressing the mismatch between the skills they were equipped with and the requirements of their jobs in veterinary practice, particularly in the area of communication skills. Manning (1998) identified the need for the establishment of a postgraduate training programme for veterinary surgeons in practice.

Hawn (1997) described similar gaps between education and practice, and described how setting up a formal training programme for graduates in communication and other related subjects could be worth the effort involved. One way that Hawn said that a practice could tell if a new associate veterinary surgeon was communicating effectively was to look at the transaction charges. Hawn reports that client confusion was linked to the vet's reluctance or embarrassment about asking for money, and the outcome was low transaction values.

Gervase (1997) described the validity and worth of a technique of coaching which starts with the premise that it is best to focus on what people do well. The technique described was called appreciative inquiry (AI).

It was noted that it was only as late as 1994 that the RCGP introduced a 'consulting skills' component to their exam. (Campion, 2004)

The SPVS Masters Group have researched and developed a proposal for a postgraduate certificate in general veterinary practice which has been presented to the RCVS Oct 2003 (Ref: [www.vetgp.co.uk](http://www.vetgp.co.uk)). This has developed from the work of the SPVS and their working party between 1998 and 2001. One notable presentation reported in the Veterinary Times was the SPVS annual conference in May 2000, when Dr Chris Chesney was SPVS President. The title of the presentation was 'Towards a Certificate in General Practice.' It was discussion at the conference and afterwards that lead to the search for a way to develop the research that was needed to provide a firm foundation for the GP Certificate, and that was when the SPVS Masters Group was formed in partnership with the Professional Development Foundation and Middlesex University, in particular with the Centre of Excellence in Work Based Learning. 'Reflection was found to be a critical proficiency essential to the effective development of high competence in communication', (Adams *et al*, 2006). This article suggested guidelines for written reflection of a patient-centred interview:

- Select one interviewing skill that you used in each stage of the interview: opening; gathering information; closure.
- For each skill that you have chosen, describe: your feelings when you used the skill; the rationale for using the skill; patient's reaction to the skill.
- What will you do to maintain your strengths?
- What will you do to improve your weaknesses?

The Spring 2006 (Adams) volume of the Journal of Veterinary Medical Education had the theme 'Communication skills in veterinary Education', and the whole volume contained articles on this subject. This was significant in that such a high profile was given to this essential clinical skill.

### **1.G.3.2. The needs for research in consultation skills in veterinary practice.**

The validity of several methodologies has been supported by published researchers, particularly in the medical literature. This was essential in the design of this research project in veterinary practice, because there was very much less research and information on the application and outcomes of the use of research instruments in exploring the skills in veterinary practice. There were also some gaps in the understanding of the research instruments, the involvement of clients/patients in the analysis, and the validity of the methods of analysis in producing credible and accountable links to key performance indicators. There were some reports of the validity of assessment of consultations in medical practice, but very few in veterinary practice, and there were many questions still to be answered about the assessment and analytical methods which might be the most effective and time efficient.

The literature seemed to fall short of producing a link between the analysis and the links to outcomes.

Money is a really important issue for veterinary surgeons in private practice. Numbers are a matter of survival. Giving 'estimates' is a skilled part of the GP vet's job in private practice, but there is very little mention of the skills or the process and method of doing this in the literature.

There were many ways in which veterinary surgeons/clinicians perceive and appreciate themselves and their colleagues in terms of their consultation skills. The challenges include a search for a set of systems that facilitate the visualisation of consultation skills and their importance so that an educational process can be developed for the benefit of the patients, clients and the veterinary surgeons themselves.

A point that has often been overlooked or given cursory attention in the veterinary world is that this is indeed a complex area, and requires serious attention. It is a discipline in its own right, just as any of the more established and respected clinical disciplines in medicine and surgery. Veterinary surgeons appreciate how complex the clinical disciplines can be and appreciate the time needed to study them to a high level in order to achieve a reasonable level of competence, but they tend to underrate the soft skills involved in consultations and this leaves the performance in this area by individual veterinary surgeons down to chance depending on whether they have a 'natural gift' or not, or a range of skills in between the two extremes. The same has been largely true of the veterinary nurses, but there is now a chapter in a newly published veterinary nursing textbook on the subject of 'owner communication', which addresses this issue. (Manning, 2006).

## **Chapter 2. RESEARCH METHODOLOGY AND DATA COLLECTION.**

No previous work had been done in this area of the world of veterinary practice, and so each step of the journey in the research required a new look at the information as each piece was collected and assembled into the whole project. There were many new concepts and new areas of research, each requiring a process of inquiry and development. Initially, the key questions were identified in the programme planning (DPS 4825 and DPS 4541). The key questions were refined in the planning stage, and the research instruments chosen from the literature, and/or developed in order to be able to answer the key questions. In essence, the critical question summarised as ‘what did a successful consultation look like, and how could it be identified?’

### ***2.A Research goals.***

- The development of the tools to collect the data was an important part of this research.
- The application of those tools to produce information, which enabled consultation skills and the client satisfaction and understanding to be identified, contrasted and compared, was also important.
- Assessment of a consultation was considered to need a more holistic view, but each of the research and analytical tools could be used to develop methods of assessment.

The planned collection of data did have some limitations, but also some strengths.



## ***2.B The design of the research and choice of methodology.***

The particular area of interest in this research was the close interaction between the clinician and the client or patient. The purpose of the research was to find practical, feasible and valid methods of measuring consultation skills in veterinary practice. The methods needed to be accessible to the majority of practices, economic in cost of resources and time effectiveness, and also consistent and reasonably reliable.

### **Literature Search.**

The literature search revealed many details of potential applications of methodologies and research instruments. The details of the fundamental questions were unpacked into a table of questions (see page 83) and the methodologies selected to research them.

### **Survey.**

Survey was also decided to be a useful methodology, because it could be used to explore the opinions and perceptions of the clients and the veterinary surgeons in relation to the consultations. Client questionnaires were planned.

### **Ethnography.**

Ethnography was attractive as a research methodology because it intrinsically involves the worker researcher, which I was, and also this was an approach that I personally favoured and felt comfortable with. This methodology offered the opportunity to become involved and enter the 'inner sanctum' of veterinary practice, an area where the veterinary surgeons have been demonstrably very sensitive to being investigated or researched.

### **Interviews.**

Interviews were planned because it was thought that the best way to find out what veterinary surgeons and clients thought was to ask them. Choices were made about

how long to spend interviewing the clients and the veterinary surgeons after a consultation, taking account of the fact that many veterinary surgeons were busy and this needed to be done during their working day with minimal disruption. At the same time, the purpose of using the interviews to explore the understanding and perceptions of the clients and veterinary surgeons was considered. The interviews were planned with a simple structure to help keep them focussed and time wise. The interviews were planned as relatively simple to avoid over complicating the data collection. Consideration was given to the possibility of carrying out in depth interviews to explore the consultation again with a fresh clinician, who was also the researcher. This would not have helped the analysis of the outcomes in terms of understanding and perception of the consultation being observed, but it might have served to analyse the missed opportunities (if any) during the observed consultation. However, the potential for bias was quite large, and the ethical considerations of potentially making a direct comparison between the veterinary surgeon researcher as a clinician and the veterinary surgeon being observed were strongly negative. Some flexibility was allowed for in asking clients questions that might have appeared obvious from the observations. It was felt that the use of short interviews would meet the needs of this research project.

### **Case Study : Training and Development Group.**

The definition of the 'training group' became a 'case study of the effects and interactions produced from the introduction of consultation skills to a general veterinary practice'. This innovative piece of research involved all of the above methodologies, which were used to explore the complex interactions and outcomes in this activity. There was a large medical literature on training, including whole Journals such as 'Medical Teacher', which would have made the scope of this research project too large to handle in the time frame. The 'group' started off with the idea of having a focus group to investigate the perceptions of the veterinary surgeons into what success was in their consultations. Then, various types of consultations were discussed and success defined. Observations were made on the reactions of the veterinary surgeons in the group to commenting on consultations and receiving some

information on their consultations. It was difficult or impossible to obtain reflections from the vets, who were not immediately attracted to the concept of training or management (either by themselves or by their employer) in their consultations. The group could not be described as a learning set because they did not reflect, until the very end of the research period.

The goal of the training group meetings was to encourage veterinary surgeons who were unfamiliar with the subject of consultation skills and its importance to explore it through facilitated discussion, clarify the issues and seek ways of improving themselves. The important objectives to the practice and the Principal veterinary surgeon were:

- To relieve the Principal veterinary surgeon of the heavy burden of a high volume of clinical work whilst also doing a high volume of management work, and being the chief generator of income through the consultations for the practice.
- To share the work in the consultations more evenly between the veterinary surgeons so that each client received a good amount of time for their consultation, relieving the need to rush through some consultations and potentially skate over or fail to elicit client concerns and simultaneously lose opportunities and income for the practice.
- To establish whether or not a system of sharing consultations between the veterinary surgeons could maintain and grow numbers of consultations and the income generated from them, when it was known that veterinary surgeons tend to move between different practices during their careers.
- In order to achieve the above objectives, it was vital to train the veterinary surgeons in consultations and the importance of the pricing strategy in order that they maintained the level of service and income when the work flowed from the Principal veterinary surgeon to the other veterinary surgeons in the team. It was important to achieve this within a time period of 6 to 12 months in order to ensure that the work flowed through the practice during a changeover of the veterinary surgeons working in the practice.
- The achievement of all of the above was critical for the practice to maintain a sustainable performance, and also to grow.

The important background to these objectives was that the practice had experienced a large change in the veterinary team, with 4 out of the 6 veterinary surgeons leaving,

two after 4 years service, and there was also a change in the nurse team with the Head Nurse leaving. There were opportunities as well as downsides to this in that a fresh start gave the opportunity to realise previously untapped potential. The practice was very busy before these big changes in the team, and had good numbers of clients coming to the practice, but this was later found to be at a cost of charging zero consultation fees in quite a number of cases (which was not in line with practice policy), and at a relatively static average transaction value. This was a particular issue for one of the vets. The nurse team also needed development, especially in consultation skills for the weight clinics because the previous Head Nurse had done an excellent job in building this part of the practice, but many of the remaining nurses were less confident in the necessary skills.

The group of 6 veterinary surgeons in my own practice started to look at the issues surrounding the vets' consultations. However, there was a training need to be explored, and the veterinary surgeons were not found to be 'experts' in the field of consultation skills, because they had had very little or no training in this area of professional practice beforehand. By contrast, consumers of retail goods can form a focus group because they have acquired an expertise and specific knowledge of selected retail products or services that they have been using. The group was somewhat resistant to training because they did not feel a strong desire to learn the consultation skills compared to their desire to further their knowledge of the more pure clinical subjects such as surgery, cardiology, and internal medicine. Coaching using appreciative inquiry (AI) (Gervase, 1997) was a possible approach, and indeed there were elements of this in the approach to the group, such as starting by asking the veterinary surgeons what they did well. Gervase found that AI had potential benefits for team development where there were a) issues the group faced, and b) there was a need for a paradoxical intervention into a group stuck in undisclosed resentment. These two factors were present, because there were issues of needing to improve consultation skills to reduce the numbers of complaints from clients and also to improve clinical and financial performance. Some reluctance was identified in the team but it was suspected that some was undisclosed.

Action Research with the teacher as researcher model was considered as a possibility for the group in my practice. It involved actively seeking out the issues in the consultations, setting hypotheses and deciding on modifications of behaviour and systems, (Brown & McIntyre, 1981), which would then be tested against a set of data. Review would be carried out, further change or ratification of the new procedures would be made, and so on in a process of continuous improvement of professional practice. The difficulty with this approach, were it to have been overtly named as such, was that the veterinary surgeons needed gentle persuasion to face a subject that they had some fear of, and in some cases this fear was quite severe.

‘Training and Development Group’ was the title chosen for the group of veterinary surgeons in my practice, because although at the outset it was overtly described as a focus group, it became apparent over the time period of the research that training and support was taking place, this was measured in various ways, and changes were achieved in procedures that were agreed, implemented and measured in process and outcome. Therefore a cycle of learning and development was taking place.

This case study included the family of research methods described, focussing on the interactions around the introduction of consultation skills to a practice. The potential for generalisation of the findings was limited by future opportunities to compare circumstances and environments in other practices where this exercise might be tried, but it was anticipated that many veterinary practices would be in similar situations because so little training in consultation skills had been established in the veterinary profession at this point in time.

### **Cycle of Learning.**

From my point of view as Managing Director, and researcher, I needed to find ways of encouraging the veterinary surgeons to think about their consultations and change their behaviours to improve. From that point of view, it was a piece of Appreciative Inquiry.

A cycle of learning did take place for both the veterinary surgeons and the worker/researcher, which had benefits for all. The group evolved as expertise grew within it, and a greater understanding of the issues and ways of tackling them was achieved. The work was part of the research and development within the practice.

## **2.C *Data collection methods and research instruments.***

The data was collected using several different methods:

1. Literature search and review.
2. Training and Development Group in my own veterinary practice.
3. Visits to other veterinary practices in which I conducted:
  - interactive seminars in which ‘the definition of a successful consultation’ was discussed
  - observation of consultations
  - audiotapes of the consultations
  - semi structured interviews of the clients and veterinary surgeons after the consultation had finished.
4. Seminars with groups of vets.

As each method was used and the research instrument applied, new questions and issues concerning the discoveries from this work kept emerging. This produced an array of reflection on previously acquired knowledge and interim conclusions from previous findings. For example, as I carried out the literature search, more questions were stimulated. More importantly, as the observations and analyses of the consultations were carried out, more questions were stimulated about the application of the research instruments designed to collect the data. The processes of data collection and delivery were themselves the subject of research and analysis.

The choice of appropriate observations and recording of the consultations was important because this needed to be practical and feasible, as well as delivering meaningful information for analysis. The choice of interview questions was pre-selected so that data could be obtained that was useful in analysing individual consultations, and also comparable between different consultations. The questions that were selected for use in the semi structured interviews had previously been used by Manning (MSc thesis 2003) :

1. What was the problem?
2. Did the veterinary surgeon give the diagnosis a name?
3. What was the treatment?
4. What was the prognosis?
5. How well did the veterinary surgeon care for the client and the pet?  
Score out of 5, 1 being very poor up to 5 as the best it could have been.
- 5a. Why did you assign the score you gave?



## ***2.D. Key research questions in the Training and Development Group.***

One of the key research questions identified in the planning of the Training Group part of the research was ‘Explore methods of training and developing veterinary surgeons in consulting skills to improve outcomes. In what ways can consultation skills be encouraged to improve performance?’ ‘ Training and Development Group was a group of people(vets) gathered together once a month for 1 hour discussion, facilitated by the researcher/worker/manager, to discuss concepts related to consultation skills. This Group in my practice formed a useful starting point for:

- Exploring the issues of finding out what could be interesting to the veterinary surgeons.
- What was effective in developing consultation skills in links to key performance indicators?
- What performance indicators were the most useful as links to consultation skills?
- What was useful in developing consultation skills for me as a key stakeholder and owner of a veterinary practice?
- What would be the most interesting and effective ways of developing a day’s training for postgraduate veterinary surgeons for the SPVS Roadshow on consultation skills for January 2006?

This part of the research was important to develop information about the attitudes and behaviours of veterinary surgeons towards consultation skills as :

- A subject in its own right.
- A subject they could learn and develop to the benefit of themselves, the practice and their clients and patients.
- Links to key performance indicators.

The approach to researching consultation skills in my own practice was to develop from the regular monthly team meetings that had been established for some years. The approach gained acceptance from the vets, whereas the suggestion of having their consultations video or audio recorded, or observed, met with utterances of horror and indignation. It was interesting to see what could be learned from a study or training group in which no intrusive observation and analysis into the consulting room was included, and to compare this with the visits to other practices in which the consultations were observed directly by the researcher in the room as well as audio recording.

The meetings were attended by all of the veterinary surgeons in the practice, which numbered 6. They included the researcher who worked in the practice. The age range was 24 years to 50 years, and the length of time qualified ranged from new graduate, 1-2 years' qualified, 15 years qualified and 27 years' qualified (the researcher). The meetings were held monthly for 1 hour each time.

The analysis of the training group reflected the desire to explore these questions and issues. This was important because the subject was new to many veterinary surgeons as a 'taught or formally learned discipline' compared to the medical profession where the clinicians have become accustomed over the past 20 to 30 years to learning about consultation skills, having seminars, being observed and conducting client satisfaction surveys.

Training was considered to be an important potential link between consultation skills and performance indicators. Different methods of training and development could provide a useful variety of links to performance, but also a triangulation of methods of training and performance analysis.

The research aim of the training group was more concentrated towards the identification of the vets' perception of a successful consultation, and how they responded to sharing information and data about those consultations. The comparison

between the use of mentoring, coaching and facilitation of reflection was beyond the scope of this project, but it was hoped that the retrieval of some data from this research would help to stimulate more learning in the future. It was important to have an awareness of these boundaries and limitations of this research project, because it was easily possible to lose focus and stray into more areas, which would have made the project unmanageable.

The advisory and teaching element was present in the Training Group because that was an intrinsic part of this research. It may have been interesting to compare the results of the use of a Training Group when present with a practice(s) where there was(were) no Training Groups. Consideration was given to extending the study of training by revisiting one of the practices in the research. This may have illustrated how they had changed after a visit in which an interactive seminar was included, but this might have been of limited value without ongoing meetings in the practice for professional development of the consultations. Also, the primary objective of the visits to practices was not training.

### ***2.E. Key research questions in the Practice visits.***

The case study of the training and development group provided some ground breaking research which was mutually developed with the visits to practices in which the research questions were explored further and in different ways. This wider group of vets enabled a more reliable definition of what vets interpret as a successful consultation, and how it could be explored with observation, interview and autiotape, all of which were not possible in the group of vets in the case study.

Variation in the facilities, consulting room layout and numbers of consulting rooms were anticipated for the visits to practices, and this was an important part of the preparations and preparatory discussions with the practices involved. It was important to ensure that the presence of the researcher–observer was acceptable and as unobtrusive as possible.

## ***2.F. Developing the methodology and research instruments.***

Exploration of key research instruments was planned for the visits to practices, where the researcher was not a worker. A selection was made from the literature search. These included interactive seminars with the teams of veterinary surgeons to determine their definitions of a successful consultation, observations and audiotapes of the consultations, and post-consultation semi-structured interviews with the clients and veterinary surgeons separately. The use of the Roter interaction analysis system (RIAS) was explored with the audiotapes. The visits to practices were an opportunity to test and compare the findings of the research and development group with other groups of vets. This was also an opportunity to explore the value of more intrusive methods of study of consultations, which were not accepted (at least initially) by the training and development group. The hypothesis was that if other veterinary surgeons welcomed and tried the research instruments, and the results proved to be valid and useful, eventually the instruments could be used in my own practice as well as other practices nationwide.

Many ways of analysing observations and audiotapes of the consultations had been found in the literature review, which were helpful in identifying the use of specific consultation skills and language. Some specific analytical points were considered to be critical to the outcome of the consultation. For example:

- percentage of talk time shared between clinician and client may be related to the amount of shared understanding between the clinician and the client as measured by the accuracy and depth of understanding discovered through the post consultation interviews
- use of a number of open questions seems to be critical to the eliciting of client concerns, (Shaw, 2004; Roter, 1977)
- explanation could be linked to client understanding especially if tested by the clinician asking the client a searching question about their understanding
- motivation of the client to comply with the recommendations could be linked to the enthusiasm of the clinician which could be difficult but important to measure; or it could be linked to an aspect of the consultation in which the

clinician explains or mentions the potential benefits which could be measured from the audiotapes

- Numbers of questions that work towards a recheck. (Ref: Clarke)
- Relative amount of time the veterinary surgeon and the client are actually speaking in the consultation. (Ref: audiotape analysis)
- Specific 3 messages given to the client at the end of a consultation. Roger Haverson, MRCVS., made this point in his presentation at a VPMA Congress (in Northampton, 2000)

Whilst this analysis was useful and interesting, both to establish which consultation models were useful and which consultation skills work in practice, there were potential limitations due to the complexity of the interaction and the environmental factors impacting on the consultation. This was where the experienced practitioner could demonstrate their understanding of the consultation from their position of inner involvement, which the ethnographic researcher hoped to be able to analyse. It was recognised that not all of the components of the analysis would be done at any one time.

The combination of the interactive seminars in the practices visited to find out what the definition of success was, plus the observations, interviews and analyses of the audiotapes, together formed a quite powerful research methodology to develop a greater understanding of the consultation in veterinary practice.

One way of approaching the analysis of the audiotapes was to see how much of each particular model was demonstrated in each type of consultation. For example, the vaccination consultations formed a group, which could be analysed separately and were also usually distinct from some other types of consultation in that a diagnosis was usually not the most important aim. Comparison could be made between the consultations which last 7, 10 minutes, 15 minutes and 30 minutes, especially on what components were present or absent. Measuring client (the patient in medical consultations) centredness was helpful because it had been identified as important from the literature (Mead and Bower 2000).

The Roter method of interaction process analysis (RIAS) offered some good categories of communication that could be analysed, so this system was chosen with some additional items such as ‘made a recommendation’, ‘promoted a product or service’. The RIAS method could be said to be an oversimplification of the assessment of the consultation compared to the method used by the Royal College of General Practitioners. However, the RIAS method had the advantage that it could be learned and applied quite quickly, it provided analysis of the audio part of the consultation which compared well to the RCGP assessment, and it provided the opportunity to gather some analysis of data within the timescale of this research project. It was also a method, which recorded and offered the opportunity to analyse the participation of both the clinician and the client in the consultation.

The RIAS method did not specifically include analysis of whether or not a prognosis or information about prognosis was discussed or information was given about prognosis. This was included in the sections labelled ‘medical information’. It could be useful to have the sections on ‘medical information’ further analysed into a more detailed subsection, or to have specific points such as prognosis analysed in the coding of the audiotape data. However, this proved to be difficult to achieve accuracy in the speed required in listening to the tapes in this project. The level of detail required to separate out the subsection of prognosis from the category of medical information could have lead to variances in interpretation by the same of different people involved in the coding.

There were some concerns about the RIAS system in that it made no attempt to take account of the amount of time spent in the various explanations or categories for the dialogue in the consultation. However, a greater score was achieved from a longer statement, which might include several utterances in one category.

The RIAS categories ‘counsels or directs behaviour for medical condition, treatment or lifestyle/psychosocial’, could be more accurately reflected by the following adaptations:

- Counsels or directs behaviour – advises on the medical or surgical condition
- Counsels or directs behaviour – recommends diagnostic or treatment programme strongly, plainly, weakly (choose as judged from interpreting the audiotape)
- Counsels or directs behaviour – advises on exercise plan for the animal, advises on behaviour training for the pet, advises on husbandry or accommodation for the animal. There was a difficulty in this in that giving the coder too many categories and subcategories made the analysis of the audiotapes very much more complex because quick decisions needed to be made to classify the remarks while listening. The provision of a greater length of time to analyse the remarks in more detail still left quite a lot to interpretation and there was a danger of some bias towards the specific targets for the remarks being searched for

Requests for services or medication initiated by the patient/client were important, as was the power and number of recommendations that the patient was given in diagnostic tests, medication or other forms of treatment.

Global affect ratings were recorded from interpreting the audio recordings for the provider of services and the patient/client as follows:

- Anger/irritation (Score 1 (Lo) to 6 (High))
- Anxiety/nervousness
- Dominance/assertiveness
- Interest/engagement
- Friendliness/warmth.

Another possible useful adaptation could have been to ask the coder the question:

Was there an incident or resistance to the recommended programme or treatment recommendation?



- direct defiance
- refusal (verbal)
- negotiation
- indirect defiance (passive/ignoring)

Towards the end of the timescale of the research project, a limited number of audiotapes were planned to be obtained from the veterinary surgeons in the training group who gave their permission. This was an opportunity to test whether or not more could be learned from the audiotapes than from the training group meetings, or whether the audiotapes could enhance the training group discussions. The question was ‘do the veterinary surgeons critique their own consultations more fairly if given the tapes to analyse them?’ This activity was designed to answer the research question ‘can analysis of consultation skills be used to predict performance?’ It was also partly a quality control to see if there was an agreement in the interpretation and critique of the audiotapes with the vets’ own critique.

## **2.G. Planning a training event.**

### **(Appendix 6)**

The organisation of the programme for the SPVS Roadshow on Consultation Skills January 12<sup>th</sup> 2006 brought a great deal of research together in one day, and brought a strength of focus to the subject matter with a real impact on delegates' professional practice. The event was an opportunity to see how some of the research methodologies were accepted by a wider audience of vets, and what would attract them to a programme in which the topic of consultation skills was the theme for the day. It also helped to obtain a wider selection of views on what practising veterinary surgeons considered to be a successful consultation.

The programme title chosen was :

**What do your clients hear?**

**How to improve your consultation skills, client compliance and profitability.**

Publicity included bullet points, which were considered topical, important and likely to attract delegates from practice. These included :

- 'You are a veterinary surgeon who wants to improve your consultation skills.
- You are an employer who cannot understand why different veterinary surgeons produce such different outcomes from their consultations.
- You are concerned about the possible effects of the VMD and DTI changes and how we can increase profit from consultations.
- You are a farm veterinary surgeon who sees the work declining and needs improved skills in small animal work.
- You have problems in managing your time to deal effectively with clients.
- You want to minimize the number of complaints that come from what happens in the consulting room.

- You need to develop a training programme in your practice or other workplace in consultation skills.
- You want to increase profitability and improve clinical outcomes.
- You want to develop yourself or your staff.
- You want to 'justify' increased consultation fees by adding value for your clients.'

The importance of consultation skills was emphasised with reference to evidence produced from the original SPVS Masters Group research ([www.vetgp.co.uk](http://www.vetgp.co.uk)) in which Manning found:

'Consultation skills are important to the GP veterinary surgeon according to all but one of the 903 respondents in a survey of 9000 veterinary surgeons.'

The programme plan included a talk on the background research (Paul Manning) and the 'baggage people bring to the consultation ranging from different perceptions of value to fatigue and pressures from home'. Compliance, the view from the Universities, and the provision of long term continuous care programmes for pets with long term needs were also included. Small group workshops were included (Dr Mei Ling Denney from the Royal College of General Practitioners) to give delegates the opportunity to discuss pre-planned questions, starting with relatively simple ones, and progressing to more challenging ones. The small groups were required to present their answers to the larger group.

## ***2.H. Issues and consideration of bias.***

Care was taken in the design and planning to ensure that ethical considerations were observed, both to observe tact in approaching the veterinary surgeons and the practices when discussing the research and obtaining permission or declining to participate. Ethical challenges included the fear and reluctance of veterinary surgeons to agree to video recording, although some vets were more fearful of having an observer in the consulting room. The aim was not to force anything on the vets which they did not feel comfortable with, and the video was feared the most of any recording tool. A requirement of the research was that permission was given by the vets and clients who participated in the study, and the ethics release form (Appendix 15) was unlikely to be signed by vets if they were asked for a video recording, but it was possible to obtain their consent to observations and audio - recording.

Consideration was given to the issues of bias before and during the project, and the following comments therefore represent both the prior consideration and the results of considering bias as the interactions in the case study\training group were explored.

The difference between a 'meeting' and a 'training or development group' included a commitment from the veterinary surgeons to learn and want to apply their new knowledge from the training meeting. Also, it was important for the training and development meeting to be facilitated. The choice was made to facilitate this myself. This had the advantage that I was knowledgeable and focussed on what the project was about, but it had the disadvantage that I was introducing bias and an influence because I was the employer. The bias of me participating was partly balanced by the fact that I had very little experience or prior knowledge of education and training in consultation skills, and so I (as the researcher) did not know what I was looking for or what to expect. It was important for me to be there because I was one of the veterinary surgeons working in the clinical team, and the performance of the employer veterinary surgeon was important to measure as 'one of the team.' These meetings were the only way found in which this group of veterinary surgeons agreed to interact in discussions and work on their consultation skills. For the meeting to have become

a true learning set, there may have been a need to recruit a facilitator from outside the practice, but if that person was not involved in the management of the vets, the feedback to the employer would have been restricted by the rules made by the self governing group. If the group could have been relied upon to produce reflections and an output of their learning, this would have been a positive output, but in this group reflections were unlikely to be forthcoming. It was decided that for this research, the presence of the employer was of critical importance. The interactions between all of the vets, (whether employer or employee), was necessary for good communication.

The veterinary profession was at an early stage of introducing and developing consultation skills as a subject, so reluctance in participation was considered to be difficult to establish a rapport between the researcher and the practice for engaging in the complex interactions necessary for the research activity.

The practices visited were selected on the basis of their interest expressed from talking and networking at meetings with vets, and so this selection was not random. Previous work attempting to use randomised selection resulted in many practices selecting themselves out of the research because they either felt uncomfortable with the research methods or felt unable or unwilling to organise the practice to accommodate the researcher (Shaw, 2004). Gratitude was expressed to the practices and the veterinary surgeons who participated in this research because it did require some organisation and effort. Some practices understandably reasoned that their workload and ability to accommodate a researcher were not conducive to helping with the research, and so they respectfully declined.

In the literature search, there was an absence of any one comprehensive model of a consultation. I opted to ask each individual practice to produce their definition or list of competencies required to deliver a successful consultation. I then observed the consultations to see whether or not the veterinary surgeons were using their defined model of success. This was a useful way of analysing the consultation skills being used. The hypothesis was that there were likely to be some similarities between what

the veterinary surgeons defined as successful consultation and what they actually did, and also some variance with this. The ideas of what constituted success was likely to have been influenced by factors such as client feedback and employment requirements, but there were likely to have been few concepts of what consultations might look like from any previous training because that was very limited in the veterinary profession up until this time.

Some bias was likely to be seen in the observations and note taking from the consultations, but the RIAS method offered a counterbalance with removal of bias from the greater objectivity with this technique, and also an open mind in the researcher who was also unfamiliar with this method before the research started.

Extract from D4541:

**Summary of Objectives and the associated uses of research instruments:**

<b>Objective/Research Question</b>	<b>Research Instrument.</b>
Analyse consultation skills. <b>Q.</b> What are they and how can they be measured?	Literature search. Observation. Semi structured interview
Analyse vets' definitions of 'successful consultation'	Meetings in visits to practices
Can veterinary surgeons define it? Does it make a difference to their outcomes? Is there a consensus of a definition?	Meetings in visits to practices. Training group. Questionnaires Interactive seminars.
Analyse vets' and practices attitudes to KP <b>Q.</b> Do veterinary surgeons and practices use them? If so, which ones?	Meetings in visits to practices Questionnaires Semi structured interviews
Analyse links between KPI's, outcomes and consultation skills	Training Group Visits to practices Meetings Observations Semi structured interviews of Veterinary surgeons and clients Literature search
Explore methods of training and developing veterinary surgeons in consulting skills to improve outcomes.	Training Group The SPVS Road Show was added
In what ways can consultation skills be encouraged to improve performance?	Training Group SPVS Roadshow added Literature search on key performance indicators added
Do veterinary surgeons associate consultation skills with caring? If so, what skills do they consider most important? Do veterinary surgeons think these skills can be measured?	Seminar. Training Group Visits to practices Questionnaires Interviews
In what ways do veterinary surgeons feel that successful outcomes are measured in KPI's	Training Group Practice visits
In what ways do veterinary surgeons feel that successful outcomes in delivery of caring cannot be measured?	Training Group
What aspects of success in consultations can be linked to KPI's?	Observations Semi structured interviews Analysis of audiotapes
Is it possible to predict performance from analysis of consultation skills?	Training Group Observation and semi structured interviews Analysis of audiotapes.

## **Chapter 3 : Origins of the sources of data.**

The raw data from each of the research methods was collected as follows:

### **3.A. Literature search.**

This was based heavily on the medical literature, with some from the veterinary literature. The papers, books and articles included research orientated work with analytical techniques, educational material about how teaching and assessment was done in the medical literature, and observations about how clinicians actually practised their consultations.

Searches included:

- HMIC Database : Analysing consultation skills, processes involved and quality. Medical literature, 1995-2004.
- *Evaluating consultation skills in the medical literature, 1995-2006.*
- Veterinary literature 1995-2006.



### ***3.B. Training Group in my own veterinary practice.***

This resulted in material gathered in the form of minutes from flip charts used in the series of meetings, which were written up in a Microsoft Word document for future reference. There were also various measurements and reflections on the performance of the veterinary surgeons in the practice. Key performance indicators (KPI's) that were used to start with were average transaction values for the individual vets, their personal gross turnover, and the numbers of transactions they did. KPI's were explored in the group, with a view to commenting on the value of these traditionally used measurements, and commenting on the possibility of newer KPI's that might be useful.

### **3.C. Visits to other veterinary practices.**

- Seminars with the veterinary surgeons in these practices produced minutes from flip charts written up in Microsoft Word. The notes written on the flip chart were a representation of the key points made by the veterinary surgeons in the seminar.
  - Observations of the consultations recorded by note taking at the time. The notes taken were the main points considered to be of value by the researcher to notate an understanding of what was said.
- Semi structured interviews with the veterinary surgeon and the client after the consultation recorded by note taking, writing down the key points considered to be of value by the researcher at the time, and written up later for easy reference and analysis.
- Audiotapes of the consultations recorded on mini disc using a pocket sized recorder manufactured by Sony. The whole consultation was recorded, except for when a few words might have been exchanged in the waiting room as the veterinary surgeon brought the client and their pet into the consultation room.
- Seminars.
  - Veterinary Christian Fellowship annual conference : minutes recorded from flip charts and written up for easy future reference.
  - Hills Practice Health Symposium : notes taken.
  - SPVS Consultation Skills Roadshow : Video recording of the whole day, and all the presentations stored on computer for future reference. Analysis of feedback from delegates.

### ***3.D. Data Storage.***

The data storage worked well in that:

- The notes taken from the observations and interviews proved to be a very good reminder and record of what took place.
- The flip charts used in the seminars and learning set meetings proved to be an excellent method of storing the opinions and outcomes expressed in the discussions.
- The audiotapes were of excellent sound quality ensuring that the dialogue could be played back and analysed without any major difficulty.

### **3.E. Validity of analytical method.**

The literature review confirmed the validity of several methodologies used in analysis of consultation skills. This research produced evidence from the application of several instruments that supported their practical use in exploring consultation skills in veterinary practice.

The use of observations raised some concerns about the introduction of bias from the observer. This was an important and challenging point when carrying out the observations in this research project. However, the use of more than one method of analysis, including the RIAS system in analysing the audiotapes, was very useful in triangulating the other observations, as well as helping to produce clarity in the results of the analysis.

There were limitations of the validity of RIAS in that this system took no account of the length of time devoted to any one or more categories of comment during the consultation, or whether or not the client understood the clinician. However, RIAS did give an indication of the gaps in the consultation skills being used, which was very useful in analysing the other observations and drawing conclusions about what consultation skills affected the outcomes.

The use of various research instruments was planned to provide evidence of the processes in the consultation, and the achievement of client understanding:

<b>Research Instrument</b>	<b>Analysis Method</b>	<b>Process</b>	<b>Client Understanding</b>
Seminars	Summary of flip chart :commonality	Yes	
Observations of consultations	Critique from note taking	Yes	
Semi structured interviews	Comparison of vet and client response		Yes
Audiotapes	RIAS	Yes	
Post consultation client questionnaire	Questionnaire		Yes

Initially and during the course of the Group meetings, I chose to write the minutes because it was difficult to persuade the veterinary surgeons to write their own notes. The next stage was to issue the minutes in a bundle for the veterinary surgeons to refer to and start to write their reflections, or to adapt their consultations, as they felt appropriate and useful. It was not possible to obtain notes from the participating vets.

It was very important that the veterinary surgeons recognised the need to reflect on 'their own practice' and/or that of their colleagues, because Adams (2006) found that reflection was an essential skill for competence in communication. This involved some 'intrusion' into their consultations, which I referred to as 'their inner sanctum' (Manning, 2003) because often veterinary surgeons do not want to go to this place and do not want to engage in discussions which might lead to critique which they have a great fear of. In this group of vets, the fear and apprehension of having their consultations observed or taped by someone else, especially their employer who was a veterinary surgeon, was very strong, so the approach proved to be acceptable and effective in significant ways. In order to really reflect on their own consultations or those of their colleagues, the veterinary surgeons needed to use the different methods of measuring and analysing consultations with some leeway on choice from personal preference. The important point was that this analysis needed to be done on their own consultations in order to demonstrate their competence and performance in consultation skills. It was really very important that the analysis reflected what the veterinary surgeons actually did, as compared to what they thought they might have done in theory.

The choice of analytical method was complex, because there were many different models of consultations, and also there was a large potential for bias because I was both the researcher and observer, and myself a veterinary surgeon with experience. This experience could have been advantageous in that it could help make judgements about the consultations and their effectiveness, but it could also have been disadvantageous because it might have introduced some pre-existing ideas and perceptions of what was good and bad in a consultation before a proper and relatively

objective analysis could be carried out. The advantage of being a worker-researcher was that I had an understanding of the consultations and potentially could concentrate on what aspects of the communication really made a difference without having to concern myself with a failure to understand the clinical points.

## **Chapter 4. ANALYSIS OF THE DATA.**

### ***4.A. The process of analysis.***

Consultation skills, methods of analysing them, and KPI's were considered separately first of all. Then, consideration was given to exploring the links between them.

#### **4.A.1. Purpose of the literature search.**

The literature search had been essential to explore the available research and the methodologies. The project was breaking new ground in a complex area, so all of the available resources were pooled together.

#### **4.A.2. Purpose of the Training Group.**

There were three main purposes of the Training Group.

- to provide an opportunity to explore the issues the veterinary surgeons face, along with their attitudes, approach and perceptions, in their own consultations in a relatively 'safe environment'. The veterinary surgeons made it clear that they would not want to have their own consultations videoed or observed in the early stages of the research
- to help them to see the value and worth of their professional skills being applied and charged for in the consultation
- to see how consultation skills could be developed without entering the consultation room, ATV to analyse what happened to the KPI's as a result of the meetings.

An example involving all three purposes, which was explored in some detail, was the vets' attitudes and approach to diet for the patients, and some detailed analysis of the KPI's that were used to measure the actual uptake of dietary recommendations and the impact on the business.

**Key Performance Indicators** were measured during the period of the project, with particular emphasis on measuring these between January 2005 and March 2006, which was the period of the main focus of the Group. The practice had a computerised practice management system, but some of the data had to be manually transferred to a spreadsheet in Microsoft Excel at one point in the data collection process. KPI's that were explored included average individual vet's transaction value, numbers of transactions and overall personal gross turnover. However, part of the research was to explore what KPI's the veterinary surgeons found most useful, and whether or not the traditional KPI's such as these were valid and helpful to them, or whether new KPI's were more helpful and more closely linked to their actual perceptions of their own performance.

#### **4.A.3. Purpose of the visits to practices.**

The main purposes of this part of the research were focussed on:

- Finding a possible consensus in a definition of a successful consultation
- Testing the usefulness of different methods of data collection
- Comparing the data on the processes in the consultations with some key performance indicators
- Exploring the use of different methods of analysis
- Triangulating the evidence and trying to make sense of the processes and results of analysing consultations

The visits to practices other than my own offered the advantage that I was not the Boss or the employer in these environments, but it was still interesting that an outside observer could be perceived as threatening or at least make the participating veterinary surgeons feel nervous in their consultations. Informal meetings with the groups of veterinary surgeons in the practices at the start of the afternoon of



observation and tape recording were an excellent opportunity to offer the veterinary surgeons a chance to air any concerns and ask any questions about the activities, and also to gain their informed consent.

The practices were selected on the basis of their interest expressed in participating. Previous studies (Shaw and others, 2004) have tried to randomly select practices but have found that often either the practice or the clinicians did not want to participate and so they deselected themselves from what was intended as a random sample. Shaw reported that 57% of veterinary surgeons contacted and 99% of clients agreed to participate in their study. This compared very well with the findings of this project in which 100% of clients agreed to participate, and were frequently very enthusiastic about being given the opportunity, whereas the veterinary surgeons were much less enthusiastic. No attempt was made to measure the percentage of veterinary surgeons declining to participate in this project because the decision was made not to do a randomised piece of research.

Asking practices to share KPI's was not an easy thing to do, because many practices were unwilling to share this sensitive information. It was not ascertained whether every practice could produce performance figures if they chose to share them, so it could not be assumed that the data was not collected for the single reason of 'being too sensitive.' However, it was possible to identify one practice which readily shared the information with the researcher (Appendices 4 & 8 : W), and one where there was some sharing of the information with the veterinary surgeons who used the data to help them with their performance (Appendices 4 & 8 : S). This provided some opportunity for comparison of the use of consultation skills between practices that willingly shared the information compared to those who did not. However, this proved to be an area of considerable complexity, especially around the issues of the relationships between the veterinary surgeons as both colleagues and employer/employee relationships, so this data is of limited value. This is an area, which could be explored in another research project.

The practices included general practice with 10 or 15 minute consultations, a specialist with 45 minute consultations and a charitable clinic with 7 minute consultations.

#### ***4.B. Writing up the raw data.***

In the process of analysis of the field work, the seminars and training group meetings were written up first, because they had good notes from the flip charts used to record what the participants said at the time, they were easy to transcribe from the flip charts to a document on the computer, and they provided a basis for thinking about what was emerging as the ‘definition of a successful consultation’ from the veterinary surgeons in seminars and different veterinary practices. These seminars helped to research the heart of the question ‘what really matters in a consultation?’

The next part of the analysis was to write up the notes from my observations of consultations and the interviews into a readily usable Microsoft word document (Appendix 5). This reminded me of the observations, and also provided a readily available source of data for the next stage, which was to analyse the audiotapes with reference to these notes.

The audiotapes were analysed by listening to them with the notes to hand. A template of descriptors of conversation was chosen from the literature as being the most user friendly and appropriate method. Some additional descriptors were added such as ‘dietary recommendations’ because this was of particular interest to this research. There was some overlap of the definitions and use of some of the descriptors, which was evident from the use of ‘gives explanation of a treatment’ or ‘gives explanation of a medical condition’, which could be applied to ‘dietary condition or treatment’. There was an opportunity in this research to explore specific aspects of the delivery of medicine and treatment, and the Roter Interaction Analysis System (RIAS) was the chosen research tool. Whilst listening to the audiotapes of the consultations, the use of words grouped into consultation skills were recorded by ticking a template to show which skills were being used (Appendix 8). This was then analysed by comparing the frequency of use and the spread of skills in each consultation, and comparing the use of skills between different practices with varying times allowed for the consultations.

Some judgements were recorded when observations were made upon hearing the audiotapes for future reference.

The observations and interviews were then revisited. Reflections were written down, and occasional reference to the audiotapes was made to confirm or re-listen to the consultations. A table of results of where the veterinary surgeon and client understood and agreed with each other was drawn, including analysis of the interviews where the comparison between consultations was not possible due to the question being inapplicable or being too sensitive and demeaning for the client to be asked. Some interviews were shortened due to pressure of time and circumstances, in which case the questions asked tended to be focussed on areas where information was most keenly sought.

#### ***4.C. Group Training meetings in my own practice***

The discipline of meetings had been developing in my veterinary practice for many years, with improvements in the following:

- setting of agendas with invited items from the participants
- better discussions and listening by the participants
- minute taking
- publication and circulation of the minutes
- archiving these minutes for future reference
- follow-up of action points
- a better structure of meetings for individuals as in appraisals, team meetings, team leader meetings and management meetings.

However, the training, development and learning achieved had been a serious challenge, especially in the area of consultation skills. There were two sides to this issue : the need for a good system of training and development, and the need to have a veterinary team that appreciated and absorbed the training provided. The veterinary surgeons had had a lot of training and education in the sciences and clinical subjects such as radiography, internal medicine and surgery, but had had no exposure to training or development of the soft skills. This imbalance in the undergraduate education and what followed as being available in their post graduate years was a key reason why the veterinary surgeons were likely to have leanings towards their clinical subjects. Another possible reason for the veterinary surgeons' leaning towards their clinical subjects was that they had established their ideas of who was 'eminent' in their fields of interest such as cardiology, internal medicine, and these people were the 'considered experts and mentors' by the veterinary surgeons, especially if the veterinary surgeons were new graduates. The various reasons for the previous failure

in training of other veterinary surgeons in my own practice in consultation skills could be summarised thus:

- veterinary surgeons had no previous training in this subject material
- veterinary surgeons were extremely sensitive about discussing this area of their work, especially because they perceived every discussion as a potentially threatening one, and they had very little positive thinking on how they might improve
- veterinary surgeons found almost any aspect of analysis of consultation skills threatening, especially if any numbers were involved such as average transaction values and personal turnover with analysis of the component parts of these financial analyses
- Veterinary surgeons had previously established ideas about which people were 'experts' in veterinary medicine and surgery
- Veterinary surgeons may have had an embedded belief in the concept that being a better veterinary surgeon and avoiding complaints against them meant building up their clinical skills and expanding on what they studied at undergraduate level
- Veterinary surgeons may have failed to see clearly, or have clearly explained to them, that there was a link between effective training and development in consultation skills and the reduction in complaints from clients. The strength of this link was explored in this training group

Veterinary surgeon team meetings had been working in the practice for some years, and appraisals had been developing since they were started in 1994. However, in both of these types of meeting, action plans were infrequently followed through effectively, and the veterinary surgeons resisted discussions about their performance against any set or agreed action points.

Veterinary surgeons were very reluctant to write reflections or minutes of their meetings and thoughts arising from them. This led to the planning of these new 'Meetings' as initially a 'Focus Group' to discuss aspects of consultations, from which notes were taken and written up by myself. A series of PowerPoint presentations were produced using topics about the consultations, and these were

designed to give some basic information, but mainly to ask some questions to stimulate discussion and debate.

This helped to overcome the previously encountered problems of teaching the veterinary surgeons about consultation skills, in which there was a failure to achieve any significant change in behaviours to stop client complaints being repeated. A potential bias here was that the veterinary surgeons in the time period of the research were not all the same as the veterinary surgeons who were 'previously taught' consultation skills in the practice. The veterinary surgeons in the research had been selected with a greater priority being given to competence in consultation skills, the practice and researcher having learned from previously poor recruitment decisions and processes.

Some reflections were produced in writing from the participants at the end of the research period..

The agendas chosen for this series of meetings were:

- What is a successful consultation? What does it look like? How do you know you have been successful? What skills are used to achieve your success?
- Veterinary nurses : What is a successful consultation?
- Chronic cases : what does success look like?
- Dietary advice, compliance. What does effective recommendation look like?
- Vaccination consultation : what are we aiming to achieve and how?
- Dental consultation. What is success? How do you motivate the client? How do you use referrals to the nursing team?
- Perceptions of pricing that can affect the consultation. What are the issues?
- Clients who say they have no money. How do you deal with this?
- Bereavement
- Rechecks. Why do we do them and need them?

- Building your clientele
- Out of hours service on the premises
- Clinical case recording on the computer

There were significant changes to the environment of the workplace during the period of this study, one of the most important of which was the new medicines' legislation introduced by Her Majesty's Government on 1<sup>st</sup> November 2005. This required veterinary surgeons to offer free prescriptions for medicines and to open up the perceived 'complex monopoly' on the supply of veterinary medicines. The result of this was that there was more emphasis on the delivery of medical services with a reduction in emphasis on the pricing of medicines.

Another change that was being sought by the managing director (who was also the researcher worker) was the addressing of the issues found by management consultant Mark Moran who spent a day in the practice and produced a report in April 2005. One of the findings in that report was that in evaluating the target of 'developing a plan which sets out how the vision will be achieved', the team (several of whom were interviewed by Mark on the day of his visit) perceived there was 'no plan beyond the new building (opened June 2002) and 'consultation' training.' A key management objective was to create and communicate a much clearer vision of the importance of the consultation as the driver of the business and delivery of medicine to the patients. This was developed further, and during the Investors in People (IIP) 3 year review in May-June 2006, the Principal (also the researcher worker) prepared and gave a PowerPoint presentation to all the practice team which addressed the issues of communicating the vision, the structure and competencies of the management team and the team members. Feedback from the whole practice, (several of whom in both the management/team leader roles as well as team members), was obtained by the IIP assessor interviewing several people from the practice on his visit in June 2006. The feedback included 'it was the best presentation Paul has given to us ever!'



‘Excellent!’ It did not change the decision of three of the veterinary surgeons to leave in August and September 2006.

The practice had been involved in this scheme since 1994, and had successfully attained and retained recognition of the IIP standard in 1997, 2000, 2003, and now 2006. This was a reporting system whereby the reviewer visited the practice, and interviewed a selection of the team members against a set of criteria to see if the practice met the standards in the national scheme. A finding from the report was that the veterinary surgeons acknowledged that the training and development in consultation skills had taken place, and was also beneficial for the veterinary surgeons and the practice, but the veterinary surgeons did not consider it to be an important part of overall development. One possibility for this was that there was no perceived link between performance in consultation skills and the remuneration of the vets, or possibly that they aligned themselves to a way of thinking which lead them to think that their development was not in line with the development of the business. The IIP report also stated that the evidence showed that learning was linked to business need, scrutinised and evaluated. The report therefore indicated that the learning was meeting the targets and needs of the business, but the veterinary surgeons did not fully appreciate the links to development.

The IIP report included the finding that the veterinary surgeons thought consultation skills development was useful with regard to areas such as developing sales and reducing complaints, but there appeared to be more of an interest in “*the clinical side of things*”. Links were found between the development of protocols, long term care plans for chronic illnesses such as arthritis, and the consultation skills needed to deliver these medical services, but the veterinary surgeons did not all appreciate or accept the link between this development of their delivery of service using their knowledge of veterinary medicine and their personal career development. Some of the veterinary surgeons did appreciate this link.

#### **4.D. Analysis of results.**

**(Appendix 3 contains the raw data).**

The analysis of these small group training meetings concerned the preparation for the meetings, the agendas and discussions, and the reflections afterwards. This was important because this was a case study involving an ethnographic piece of research in which the exploration of the issues involved in discussing consultation skills with the veterinary team on an ongoing basis could be related to key performance indicators of critical importance to the business and to the delivery of service.

When actual practising veterinary surgeons were asked ‘what their definition of success is?’ there tended to be a shying away from the financial parameters, (both in the training group and in the visits to practices), and in fact other aspects that can be measured such as numbers of Electrocardiograms (ECG’s) carried out. Confronting veterinary surgeons with performance indicators of this type in numerical form was found to be very demotivating for many of them, although some veterinary surgeons in some practices positively thrive on these numbers and work hard towards improving them. There were huge differences between the personal turnover per veterinary surgeon and the average transaction value for each veterinary surgeon both in national surveys (Anval, 1986-2006) and even within individual practices. All of these points were found in both the training group and in the visits to other practices, and in discussions with veterinary surgeons in preparing the ground to find practices and veterinary surgeons willing to enter into this research.

In considering the data that had been collected, there were many considerations of bias, variables and complex reasons for the outcomes of the group meetings. Whilst some of the data could be presented in table or graphical form, there were many points that required presentation in a written form so that the interpretation of the data could be explained with the best clarity.

In analysing the data, consideration was given to the changing circumstances of the personnel employed in the practice, and some variable parameters were measured. These included the interaction and participation of the nursing team, the receptionist team, the management of the practice, and key performance indicators such as average transaction value, numbers of transactions and an analysis of the distribution of numbers in different types of consultations involving both veterinary surgeons and nurses. ATV's were considered for vets, nurses and receptionists.

## **4.E. Group Discussions.**

### **4.E.1. The veterinary surgeons' definition of a successful consultation**

This topic was explored in the first of the meetings, (February 2005). The answers they gave were:

- 'correct diagnosis and treatment
- satisfied client
- client understands and agrees
- the veterinary surgeon has met the client expectations
- the owner is ideally convinced about what the veterinary surgeon is saying and recommending
- the animal is happy
- and the veterinary surgeon is happy.'

The veterinary surgeons described successful outcomes as being indicated by 'the client brings the animal back for a follow up, the desired or anticipated outcome is achieved, the owner thanked the veterinary surgeon and was appreciative, the client asked to see the same veterinary surgeon the next time they came to the practice, choices were offered to the client.' One surprising comment was 'if the owner is happy, the veterinary surgeon is happy, even though the outcome was not what the veterinary surgeon wanted.' The veterinary surgeons gave examples of indications of failure as 'a moaning client, the outcome was not the desired or anticipated one, the client asked to see someone else when they next came to the practice, the client misunderstood what was said, the veterinary surgeon knows the client is not going to comply, especially if they agree too quickly to a recommendation.'

The skills thought to be involved in achieving success included taking time, talking, encouraging, giving examples of previous cases, and promoting services ‘as long as it was not selling.’

One comment from the veterinary surgeons was that they found it more difficult to relate to a generic definition of success than to a specified type of consultation.

#### **4.E.2. The chronic case with specific reference to arthritis**

This topic was explored at the 18<sup>th</sup> March 2005 meeting. Some consultations had a specific problem with an acute presenting sign such as an injury from a road traffic accident, which were arguably placing the veterinary surgeon in a position of an obvious responsibility to care for the patient and the client by force of the circumstance. A chronic illness which was not immediately life threatening was a different category of consultation requiring an approach, enthusiasm, and professionalism which some of the veterinary surgeons agreed was at least as interesting as the acute case provided the opportunities were proactively explored.

Skin problems were always in the eye of the client who saw the redness or the itching all the time, but a heart problem or internal medicine problem could be hidden from view and produce less concern in the client, although it could be more of a threat to the health of the pet. Monitoring systems such as auscultation with a stethoscope, exercise tolerance in terms of how many yards the dog could walk comfortably before having to sit down, were very important in the consultation.

In a case of arthritis, the degree of stiffness in the morning could be a useful measurement if linked to the timed period it took the dog to get up and walk normally as observed by the client. Improvement in degree of lameness after an orthopaedic operation was considered to be a useful guide.

A Likert scale was introduced and a template inserted onto the practice computer system for use in arthritis consultations. This was simply asking the client and the veterinary surgeon to score the following on a scale of 1 to 10, 10 being the best the dog had ever been, and 1 the worst possible:

**Client:**

- How keen is your dog to play and/or go for walks?
- How stiff is your dog first thing in the morning?

- How lame is your dog?
- Do you think your dog is miserable or depressed?
- How difficult does your dog find climbing stairs or jumping into cars?
- How hard does your dog find it to get up from a lying position?

**Veterinary Surgeon:**

- Joint pain?
- Joint range of movement?
- General demeanour?
- Crepitus?
- Degree of lameness?

This proved to be a useful way of improving the consultations, adding value and improving client compliance because it added a good method of reassessment of the problem in the reassessment consultation some weeks and months later.

#### **4.E.3. Making effective recommendations**

This topic was explored at the April 2005 meeting. The definition of a successful consultation was revisited by the Group. The most important points that the veterinary surgeons made were:

- Keeping client happy; observation of facial expression is important
- Correct diagnosis and treatment
- Client understands : use open and closed questions
- Veterinary surgeon is happy; needs a good working environment.

One veterinary surgeon (F) said that the most important part was for ‘the veterinary surgeon to be happy, and this would mean (for this veterinary surgeon at least) that everything was being done scientifically. Chronic cases could be just as interesting as acute cases, provided some background information was available or possible to find.’

**Diets**, their uses and when and why they should be recommended produced a large amount of discussion. One veterinary surgeon said she ‘felt she achieved a very high level of compliance with putting urinary obstructed cats onto a prescription diet after the initial treatment in the acute phase of the disease.’ The same veterinary surgeon felt she had a problem ‘talking about overweight pets in front of overweight owners.’ Discussion followed about how to depersonalise the situation and focus on the health benefits for the pet of reducing the bodyweight. Also, from a previous meeting with the nursing team, the nurses had said they think they achieve more than 90% uptake of slimming diets when clients attend their weight clinics for dogs and cats. This was a strong message from the nurses to the veterinary surgeons requesting referrals to their weight clinics. This could be done quite easily by offering an appointment at the time of the veterinary surgeon consultation, or printing a label for the nurse to follow up afterwards. The ideal situation was an immediate referral to the nurse, but this was not always possible due to time constraints of the client and the nurses.



Weighing the animals was agreed to be a good practice at the time of the consultation. Three ways to improve the percentage of consultations in which this took place were suggested:

- Receptionists to ask the client to weigh their pet on their way in to see the veterinary surgeon or while they are waiting
- Veterinary surgeons and nurses to put more effort into weighing and recording the weight of pets in their consultations
- Veterinary surgeons to ask clients to weigh their pets while they are writing up the clinical notes on the computer to save time

An environmental factor was identified and discussed. The consulting room doors had no handles on the waiting room side, which some veterinary surgeons found an obstacle to getting the pets to the scales which were located on the waiting room side of their door. This was necessary for Health and Safety to prevent unauthorised access to the consulting rooms. Whilst it was acknowledged this was an obstacle, it was only one of the obstacles obstructing the veterinary surgeon from giving a recommendation to reduce the weight of their pet.

The team empathised with the mission statement of Hills Pet Nutrition which was 'We aim to promote the health and well-being of our patients for their own and their owners' enjoyment of a longer and happier life.'

The veterinary surgeons agreed that the needs of dietary management should include an avoidance of obesity and related clinical conditions such as diabetes, liver disease, arthritis and heart disease. Avoidance of calcium and protein imbalances was important for the growing puppy and nursing mother. Control of protein intake was important for renal patients.

The veterinary surgeons said that in talking to clients about their overweight pets, the client often felt they were feeding a minimal amount already, but on the other hand clients were horrified to find out in retrospect that their pet was 4 times more likely to

get diabetes if they were obese. The veterinary surgeons agreed that an average cat weighs 4kg, 5-5.5kg for a Maine Coon cat. The veterinary surgeons agreed that the maximum bodyweight on the bag of Hills Feline RD for 'slimming overweight cats' was 6kg. This was because no cat should weigh more than this, and this actually meant that there were quite a lot of cats who were seriously over this bodyweight and were in need of some serious slimming for the benefit of their health.

#### **4.E.4. The dental consultation**

This topic was explored at the May 2005 meeting. Three main types of dental consultation were identified:

- Opportunistic as a result of examining the dog for another presenting symptom
- Opportunistic as a result of the animal being presented for a vaccination
- Primary dental consultation as a result of the client bringing the animal with a concern about the teeth and/or bad breath

#### **4.E.5. Re-visiting various topics**

The following topics were re-visited at the June 2005 meeting.

- Consultations with clients who say they have no money.
- Consultations where bereavement and grief are present.
- Rechecks : why we do and need them.
- Building a clientele.

A protocol for the handling of euthanasia consultations was subsequently developed and arose out of a need to address several issues. During the discussion and implementation phases, there was still a lot of discussion and more issues raised by the team members involved; i.e. veterinary surgeons, receptionists, administration team, and to a lesser extent the nurses. A change in procedure was sought to address the issue of payment for the euthanasia and importantly the issue of addressing the client concerns and payment for individual cremation of their pets when requested. This was clearly a very sensitive area for clients and team members, but unless addressed appropriately, the problems arising in the outcomes of these consultations could produce distress for the clients and financial embarrassment for both the client and the practice.

A key reason for clients returning to the practice for monitoring the results of treatment is that a specific concern has been discussed and specific measurable agreed realistic and timed (SMART) objectives have been produced. The important point about a recheck is that it is to confirm progress or prognosis against an agreed plan, and part of the purpose is to ensure that the plan is adhered to and is working or if not suitable changes can be made.

#### **4.E.6. Perceptions and issues that can affect consultations and pricing**

These topics were explored at the July 2005 meeting. The researcher-worker pointed out that often when a client asked the price, they were really asking for more explanation either of the diagnostic processes being recommended, or the likely prognosis or chances of successful outcome. Most of the veterinary surgeons stated that they had their biggest problems with clients who said they 'had no money or could not afford the treatment'. This was a point that regularly came into discussions with the vets, and the researcher-worker kept reinforcing the point that the client who was difficult was almost always overanxious or worried and needed extra support, explanation and reassurance. The issue was very rarely the money, and if it really was then options needed to be discussed. The tendency for veterinary surgeons to lower their recommendations when challenged on cost was a serious problem, especially when it tended to influence their whole day's work. There was a need to think more positively and realise that the majority of clients were wanting the best for their pets and were willing to pay for it or had insurance in place to allow for the best to be done. 25% of the pets in the practice were insured at this point in time, and efforts were being made to increase this number.

The perception of the veterinary surgeons of price, value, and product or service was a strong factor influencing the ability of the veterinary surgeons to recommend, and secondly to apply the normal practice price on the computer. The problem of undercharging or not charging at all for a service was identified, and there was more of a problem with this with some veterinary surgeons than others.

#### **4.E.7. Discussion**

**Some follow up** of the training and development was done during the year 2006, in particular at a veterinary surgeon team meeting 22<sup>nd</sup> March 2006. The perception of the veterinary surgeons was that they always charged a price for a 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> consultation fee, except in some circumstances where the consultation was a post-operative check up for example.

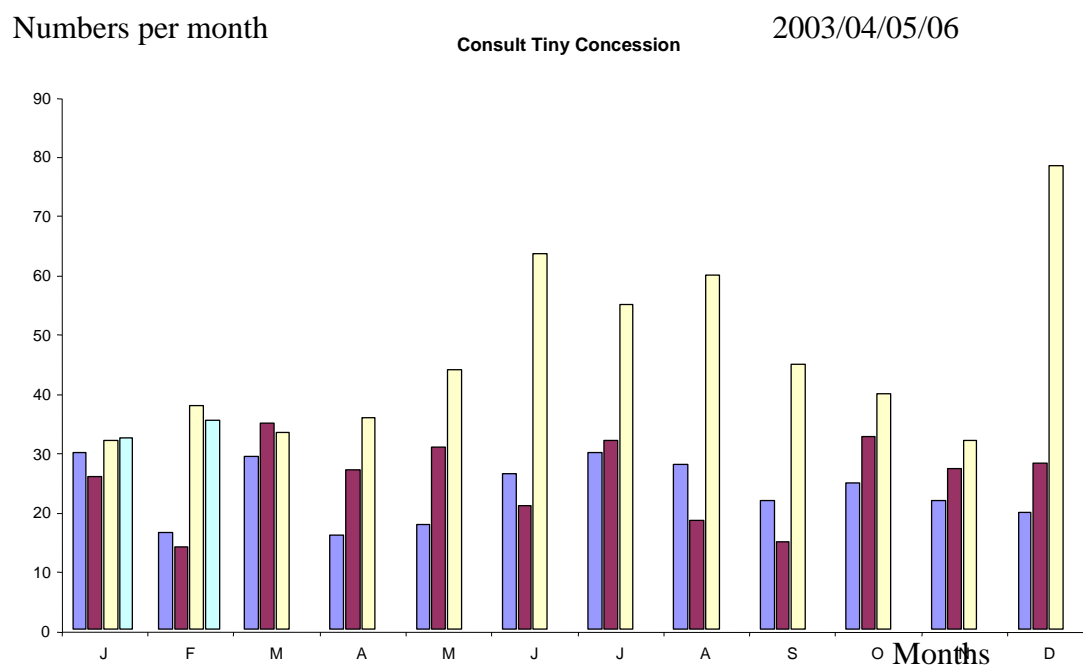
During the first part of the critical time period, a practice administrator collected the data, and recorded a drop in the numbers of 2<sup>nd</sup> and 3<sup>rd</sup> consultations, and an increase in the numbers of 'consult tiny concession fees'. However, when a new manager arrived as a replacement for the administrator who left after 9 years loyal service, the figures for these indicators were much more exaggerated, showing a jump in numbers of 'consult tiny concession fees' from about 25 per month 2 years previously to up to 80 per month over the past 12 months. This 'jump' was less strong when reported by the previous administrator who reported up to 50 per month 'consult tiny concession fees'.

This was an important point, because in managing the practice as the Principal and owner, the failure to significantly raise the overall gross turnover was not in line with anticipated levels given the relatively similar numbers of clients and transactions per month overall, and also the significant rise in average transaction values for the vets.

The figures produced by the new practice manager who started in October 2005 were more believable and seemed to be more in keeping with the holistic view of the practice performance figures.

The reality presented to the team in graphical illustration was that they had increased the number of charges being applied as a 'consult tiny concession fee', which was hardly any more than the price of a consultation with a nurse. The numbers had started to rise from May/June 2005 from a previous monthly average of about 25 to 60

or even 80 in a month. This was only a few months after the Learning Set had started. This was considered an undesirable effect by the major stakeholder, who was the owner of the veterinary practice. The discussion continued along similar lines as a previous Training Group meeting in 2005 in which one veterinary surgeon said the example of examining a corneal ulcer in the eye of a dog only took a few minutes, so the veterinary surgeon experienced difficulty in charging a proper fee. When asked ‘why did you not give that job to a nurse?’ the veterinary surgeon responded (as she did last year) that ‘it could not possibly be done by a nurse because the nurse has not got the expertise, training and experience, and is not qualified to deal with that clinical problem’. This was interesting because the previous training had not changed the vet’s approach to the issue.



Key: 2003 = blue  
 2004 = maroon  
 2005 = yellow  
 2006 = turquoise

*A key point made at this March 2006 meeting was that the ‘consultation is a unique selling point’ for the practising GP vet, without which we would have little or no business.*

The result of bringing the new analysis of the numbers of 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> and consult tiny concessions to the veterinary surgeon team at the March 2006 meeting in a very clear visual representation resulted in an immediate acceptance of the need to address this issue by the veterinary surgeon team. This also produced a list of reasons from the veterinary surgeons explaining why they had not been charging these ‘set rates’.

<b>Reason for not charging standard consultation fee</b>
Previous vet had not charged any consultation fees at all.
Perception that a ‘quick check’ had low value
ATV’s were going up
Fear of overall price charged to client
Fear of rejection of recommendations
Fear of upsetting the client
Fear of losing the client

Another example of a follow up of the Training Group outcomes was a ‘client post consultation satisfaction questionnaire’ which was placed on the reception desk at the practice for a period of approximately one month for clients to fill in. This was designed to research how many consultations were producing recommendations for parasite control and prescription diets, and how satisfied the clients were with the service. A sample of the analysis at the end of March 2006 is tabulated as follows:



### Client "Post Consultation" Satisfaction Questionnaire

Why Did you Visit Us today	Age of Pet	Satisfaction Score 1 - 5	Concerns not Addressed	Parasite Control Discussed - if so what product	Prescription Diet Recommended - if so which one	Any other Suggestions / Comments
Lump Removal	6	5	None	No	No	Astonlee have gifted staff - excellent service
Check-up	5	5	None	Spot on Flea Treatment	No	None
Check-up	7 months	4	None	No	No	None
Second Vaccination	10 weeks	5	None	Stronghold	No	Always willing to listen - good suggestions via Newsletter
Nail Clip & Wormer	10 months	1	None	Discussed	No	None
Dental	8	5	None	No	No	Great Service - Thank You
Stitch Removal	6 months	5	None	No	No	100% Satisfied
Ongoing Treatment	11	5	None	No	Already on one	Good service - Reception always helpful
Check-up (Rabbit)	3	5	None	No but up to date	No	Excellent service
De-matt of Cat	12	5	None	Requested as Usual	No	None
Rabbit Vaccination	4	5	None	Not on this occasion	No	Good service from Reception to Vet - like the Newsletter

Why Did you Visit Us today	Age of Pet	Satisfaction Score 1 - 5	Concerns not Addressed	Parasite Control Discussed - if so what product	Prescription Diet Recommended - if so which one	Any other Suggestions / Comments
Booster Jab	5	3	None	No	No	None
Booster Jab	6.5	5	None	No	No	Very happy with service - recommended you to everyone
Booster Jab & Blood Test	15	3	None	No	No	Friendly helpful staff - Waiting time could be reduced
Booster Jab	8	5	None	Up-to-date with Frontline	No	None
Guinea Pig with Abscess	2	5	None	No	N/A	Everything OK
Dog Skin Infection	13	5	None	No	No	Always satisfied
Post-Op Check	10	1	None	No	No	None
Check-up - Urinary?	13	5	None	No	No	None
Vaccination	3	5	None	No	No	Good Service
Booster Jab	8.5	5	None	Panacur Favourites	No	Very good service already
Injection	6 months	5	None	No	No	Very good service - no need to improve
Nasal Discharge	10	5	None	No	No	None
Dog Vomiting Blood	9 weeks	5	None	Panacur 10%	No	None as yet!
Skin Condition	16 months	5	None	No	No	Satisfied

Why Did you Visit Us today	Age of Pet	Satisfaction Score 1 - 5	Concerns not Addressed	Parasite Control Discussed - if so what product	Prescription Diet Recommended - if so which one	Any other Suggestions / Comments
Stomach Upset	6	5	None	No	No	None
Ear Problem	9	4	None	No	No	None
Stock-up on Supplies	10,11,16	5	None	No	No	Wonderful service every visit
Poorly Dog	10	5	None	No	No	Happy with service
Budgie Not Well	7	5	None	N/A	N/A	None
Heart Scan	7	5	None	Wormed at last visit	No	None
Check-up on Skin Condition	5 months	5	None	Didn't need to discuss	No	None
Vaccination	2.5	5	None	No	No	None
Vaginal Discharge	3	5	None	No	No	None

These results showed that very few vaccination consultations resulted in recommendations for flea and worm products, and prescription diets were not recommended, even when there were cases in which they could have been appropriate such as urinary problems or vomiting. Further explorations were made into the recommendations of life stage diets, which were appropriate at the time of vaccinations. The number of recommendations was increased by introducing and developing the numbers of vaccination consultations in which the nurse gave a 10 minute consultation in addition to the veterinary surgeon consultation. The logistics of organising and managing the change to having nurse consultations alongside the veterinary surgeon consultations proved to be challenging but worthwhile. Some of the issues included :

- Clients who had had a puppy or kitten before did not often want the extra consultation with the extra time allocation
- Clients who had a puppy or kitten for the first time welcomed the opportunity of the added nurse consultation
- Availability of consulting rooms and the nurse at times coordinated for client convenience without waiting time being added was difficult to achieve.
- Clients who wanted a microchip on the second vaccination 2-3 weeks after the first were happy to have their appointment with the nurse on the second vaccination appointment
- Clients bringing their pet for an annual booster vaccination were much less accepting of the offer of an added nurse consultation.

**Table showing numbers of vaccination consultations done by the vets which also had a consultation with a nurse either immediately before or after the client saw the vet.**

Month	Jan 04	Feb 04		Jan 06	Feb 06	Mar 06	Apr 06	May 06	June 06	July 06	August 06
Numbers of vaccination consults done by vet and also nurse	0	0		6	3	7	7	6	11	10	

The group meeting at which 'effective recommendations' was the main agenda, had very little impact on the frequency of the veterinary surgeons in the team to recommend prescription diets, if the above type of data is the basis for that interpretation. Another method of analysis was the 'Management Analysis Index' (MAI) run by AT Computer Systems in conjunction with Intervet UK Ltd. In this analysis, the % of dogs and the percentage of cats on prescription diets and on life stage diets was calculated and reported. These figures indicated a very high uptake of the diets compared to both the regional and national averages.

**This table represents a comparison of the percentages of dogs and cats who started on a prescription diet in the training group practice compared to regional and national figures produced in the MAI data.**

	1stQuarter 2005	2 <sup>nd</sup> quarter 2005	3 <sup>rd</sup> quarter 2005	4 <sup>th</sup> quarter 2005
% dogs on prescription diet	25.55 Reg av 6.19 Natl av 7.66 Natl High 25.55	24.3 Reg av 10.62 Natl av 8.52 Natl High 28.63	<b>23.08</b> Reg av 4.77 Natl av 7.32 Natl High 28.45	20.57 Reg av 4.90 Natl av 7.38 Natl High 28.50
% cats on prescription diet	19.55 Reg av 7.58 Natl av 10.38 Natl High 15.21	16.67 Reg av 10.11 Natl av 10.29 Natl High 29.87	15.5 Reg av 7.00 Natl av 10.54 Natl High 29.18	13.57 Reg av 7.20 Natl av 10.00 Natl High 28.35
	1 <sup>st</sup> quarter 2006	2 <sup>nd</sup> quarter 2006	3 <sup>rd</sup> quarter 2006	4 <sup>th</sup> quarter 2006
% dogs on prescription diet	19.16 Reg av 5.14 Natl av 7.88 Natl High 27.99	18.91 Reg av 5.14 Natl av 8.21 Natl High 28.43		
% cats on prescription diet	12.57 Reg av 7.7 Natl av 9.88 Natl High 27.58	12.91 Reg av 8.16 Natl av 10.78 Natl High 28.53		

Reg av = Regional Average.

Natl av = National Average.

Natl High= National High.

The chart above shows that the percentage of dogs and cats who received a first bag or tin of prescription diet reduced during the period of the training in the quarterly periods January-March 2005 to March-June 2006.

This method of analysis of a KPI was useful when a single event in an animal's life was the only one relevant, eg: neutering measured in numbers of cats or dogs neutered. The use of KPI's in the sale and use of diets required more complex interpretation.

The KPI that was also useful was the volume of prescription diets sold during the period of the research, which was analysed in the MAI.

**Total prescription diets sold from all manufacturers in a calendar year.**

	Jan 03-Dec 03	Jan 04-Dec 04	Jan 05- Dec 05	Apr 05-Mar 06
Dog	£17516	£19810	£17412	£18208
Cat	£15389	£16892	£16612	£17523

This showed that the actual volume of sales of prescription diets was in a rising trend during the period of the research, so the conclusion was that although a lower percentage of first recommendations was being accepted by clients, the rate of compliance and long term adherence to the recommendations increased during the period of the study.

An attempt was made (Group Meeting April 2005) to ask the veterinary surgeons to say on a scale of 1 to 5 how frequently they would recommend a prescription diet for a given medical condition. Examples included kidney disease in the cat, obesity in dogs and cats, gastroenteritis in dogs and cats, dental disease. An effective means of analysis of the frequency and effectiveness of the recommendations seems to be a client questionnaire or interview after a series of consultations as above. The nursing team were also involved in giving dietary advice, particularly supporting the veterinary surgeons in weight management. It was interesting to note that the purchases of prescription diets from one important manufacturer had been sliding downwards during the year from March 2005 to October 2005. However, in November 2005, the practice introduced a new client loyalty scheme for the prescription diets for this manufacturer, which gave the same benefits as the scheme, which had been established for over 5 years for Life Stage Diets. This one change seemed to result in the arrest of the decline in sales and produce the start of a new growth in sales. The perception of the veterinary surgeons and the clients may be affected by judicious pricing, which appeared to affect the delivery of appropriate diets to meet the patient's needs.

Table of £ monthly practice purchases of prescription diets from one manufacturer

Month	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Cat	11138	9845	10058	9915	9875	10204	10543	10433	10936	10837	10793	11244
Dog	15547	13994	14854	14454	13194	13034	13454	12835	13016	13216	13631	13823

during the period March 2005-Feb 2006.

Table of monthly practice purchases of prescription diets from one manufacturer during the period from March 2006-

Month	Mar	Apr	May	Jun
Cat	11215	11112	11505	11953
Dog	13745	13655	13739	13722

The prescription diets were an area of the practice over which the veterinary surgeons had a significant influence. The other influences on the uptake of the recommendations were the nurses who were working on obesity clinics and influencing the sales of slimming diets, and both the nurses and receptionists had an influence over the reinforcement of the recommendations made by the vets.

The veterinary surgeons did produce some positive outcomes from the discussions, and two of the veterinary surgeons set about establishing junior clinics and senior clinics. They drew up protocols following further discussions and involvement of the nursing team. The clinics were launched using mail shots to clients identified as having pets in the right age groups. Literature for the mail shot was designed by the vets, and the outcome was very positive. As at May 2006, there were 270 invitations sent out to clients with pets in the 6 to 12 month age group, and there was a 10% uptake from clients. The senior pet clinics were also a success, and more services were generated for the benefit of these pets, including dental care, identification and removal of tumours, identification of kidney problems and diabetes, all of which were treated. Many senior pets were found to be in good health and their owners were reassured and given some advice on how to help keep them healthy with dietary advice.

#### **4.E.8. The Fear Factor**

Discussions with the veterinary surgeons on 26<sup>th</sup> May 2006 addressed the fears of participating in recording of their consultations. Veterinary surgeon (D) said she 'wanted anonymity which I had achieved in visits to other practices.' Whilst anonymity was not an issue for the audience outside the practice, it was felt that inside the practice there were fears of others criticising a veterinary surgeon who they could probably identify. The benefit to the patient, the client, the practice and other team members, as well as the veterinary surgeon themselves as a learning exercise was emphasised. The response was still negative. One veterinary surgeon (E) said she would not agree to an audiotape, but would write 600-800 words of reflections on the whole activity in consultation skills. One veterinary surgeon (B) agreed to participate and have audiotapes made and analysed of her own consultations. The decision of the individual veterinary surgeons who decided not to have their own consultations recorded in any way was accepted.

The discussions included making the point that the veterinary surgeons could learn a lot from the audiotapes, because what they thought they said may not actually be what they said, and also a deeper understanding of consultation skill could be acquired by examining this data carefully, in the same way as viewing many radiographs with tuition and books could help to improve understanding of radiology. The ability to listen and probe client concerns more deeply was a positive advantage of developing the skills, as was the potential for reducing the stress the veterinary surgeons felt when dealing with 'difficult clients' as they perceived them.

It seemed that the veterinary surgeons had a fear of assessment of both competence and performance. They appeared not to perceive a link between the constructive analysis of their consultations and the potential for them to improve.



#### **4.E.9. Summary of key results of Group meetings.**

Key points in achieving success in the Group meetings included:

- Stimulation of some discussion by encouragement of the vets, positive feedback, and introduction of the idea that it would be great to have some meetings about consultation skills on topics chosen by the veterinary surgeons and by the researcher.
- The typical meeting had minutes, but often these would have been missing or lost by the attendees. Instilling the discipline of meetings into the veterinary surgeons and the reasons why meetings are most effective to help them move forward so they have a benefit for them was important.
- The elimination of complaints and the threat of being sued was an extremely powerful motivator for young graduates (and for many others), and improved delivery of best medicine/getting clients to do what the veterinary surgeons recommend more frequently was also a greater motivator than 'earning more money'. More money did follow as an outcome, but if given as a first prime reason for doing this, the veterinary surgeons resisted the approach. The reason for this was that the focus on the processes taking place in the consultation was misplaced too soon so that not enough thought was given to the details of the processes involved in delivery of the outcomes.
- The veterinary surgeons needed to discuss and set rules of the meetings at the outset, mainly to establish the boundaries and safety netting so they knew they were free to discuss and not be sacked or penalised for being 'open' about their comments.
- The 'reflections/thoughts about the meeting and what they learned from it' needed to be recorded and written up after each meeting. These were circulated and

allowed to generate more thought and comment in the group. The veterinary surgeons were not forthcoming in responding to requests to write their reflections, so notes were written by the researcher, recorded and circulated to the veterinary surgeons asking them to comment on their accuracy. Reflection needed to be encouraged, but it was not always easy to achieve, hence the support of discussion and encouraging the participants to write their thoughts down in a safe environment. The failure to achieve personal reflection from individual veterinary surgeons appeared to be linked to a failure to achieve behaviour changes that were important in improving consultation skills. Good examples of this included one veterinary surgeon who found it difficult to charge properly for consultations and gave the same reason for not wanting to charge a 3<sup>rd</sup> consultation fee instead of a tiny concession fee at the end of the period of group meetings as at the beginning. The world view of this veterinary surgeon had not changed, even though from the practice management point of view this was costing the practice a lot of money and giving out the wrong messages to clients about the value of professional time and the need to charge for it.

- It was important to have a series of meetings so that learning cycles could be achieved and embedded.

#### 4.E.10. Key Performance Indicators.

The difficulties, challenges and time involved in producing accurate and truly representative figures to represent key performance indicators using various types of practice management system was not underestimated. The accuracy of these results did affect the management decisions taken as a consequence of analysing the KPI's, and the links between consultation skills and KPI's could be confused by inaccuracies in this process. The computerised practice management system that was used during the period of this research was able to produce figures for average transaction values, gross turnover, personal turnover for each vet, and an analysis of the numbers of products and services sold. However, the system could not analyse the activities within the figures for each individual veterinary surgeon to show what numbers of products and services were attributable to each veterinary surgeon except for a broad category of 'fees' and 'vaccinations.'

Month	Vet	No clients seen	£ATV	£Gross turnover
<b>Sept 2004</b>	A	246	54.54	13417
	B	92	48.04	4420
	X being replaced by C	191	45.53	8696
	D	310	48.53	15044
	E	Starts Oct 04		
	F	239	37.47	8955
	Y leaving	278	54.48	15145
	Team ATV=47	C	172	38.21 6572
<b>Oct 2004</b>	A	271	63.81	17292
	B	83	51.58	4281
	C	316	41.42	13090
	D	413	43.76	18071
	E	25	45.62	1141
	Team ATV=	F	238	34.17 8133
<b>Nov 2004</b>	A	193	61.89	11945
	B	109	57.77	6297
	C	301	44.13	13283
	D	314	46.04	14457
	E	212	34.19	7248
	Team ATV=45	F	237	33.4 7916
<b>Dec 2004</b>	A	292	66.84	20042
	B	91	50.99	4640
	C	261	46.55	12150
	D	218	48.88	10655
	E	142	34.57	4908
	Team ATV=	F	280	41.53 11627
<b>Jan 2005</b>	A	231	65.13	15045
	B	92	53.07	4882
	C	277	53.45	14801
	D	284	46.58	13221
	E	112	34.23	3834
	Team ATV=49.73	F	244	40.5 9882
<b>Feb 2005</b>	A	268	71.42	19141

	B	90	53.78	4840
	C	355	48.57	17241
	D	229	39.89	9134
	E	162	43.20	6998
Team ATV=50.91	F	219	45.65	9997
<b>March 2005</b>	A	246	54.89	13502
	B	93	51.72	4810
	C	283	63.18	17880
	D	234	52.58	12305
	E	201	50.76	10202
Team ATV=54.25	F	233	48.41	11279
<b>April 2005</b>	A	301	60.18	18115
	B	64	55.65	3562
	C	332	47.05	15620
	D	293	45.89	13445
	E	142	43.73	6210
Team ATV=51.6	F	267	57.29	15298
<b>May 2005</b>	A	201	63.48	12760
	B	75	55.93	4194
	C	308	53.67	16532
	D	321	52.95	16995
	E	165	45.00	7424
Team ATV=53.55	F	246	51.09	12568
<b>June 2005</b>	A	293	61.47	18011
	B	96	60.87	5844
	C	250	45.15	11288
	D	277	61.85	17132
	E	132	51.91	6852
	F	274	57.96	15881
<b>Dec 2005</b>	A	288	55.14	15879
	B	89	51.51	4585
	C	201	48.92	9833
	D	273	52.07	14215
	E	175	55.22	9664
	F	178	56.72	10096
<b>Feb 2006</b>	A	286	66.82	19110
	B	68	56.37	3833
	C	208	50.82	10571
	D	327	55.51	18152
	E	207	48.83	10108
ATV=57.89	F	239	64.89	15509
<b>March 2006</b>	A	317	53.78	17049
	B	92	60	5540
	C	311	55.74	17334
	D	220	62.70	13795
	E	216	50.25	10854
ATV=57.18	F	213	64.34	13705
<b>May 2006</b>	A	200	56.58	11316
	B	67	58.12	3894
D planning to	C	282	53.13	14981
Leave Aug 06	D	283	40.79	11544
	E	159	51.15	8133
ATV=53.14	F	243	64.63	15705
<b>June 2006</b>	A	305	52.38	15976
	B	88	58.29	5129
	C	291	49.37	14367
	D	478	31.44	15027
	E	134	48.11	6446
ATV=45.78	F	288	54.05	15566

The above figures for average transaction values have some significant points where this Key Performance Indicator has improved. Firstly, two of the veterinary surgeons E and F had low ATV's at the start of the programme, £33 to £34. By the end of the programme these had almost doubled to around £48 and £64. The numbers of consultations/transactions had increased from around 140 for E to over 200, whereas the numbers for F had remained constant at around 239. The ATV for C had also increased significantly from £38 to £50. The ATV for D had remained fairly static at around £55, but the numbers of consultations/transactions had tended to grow significantly. Also, when the numbers of transactions were at their highest, the ATV tended to be lower. (Oct 2004 ATV=44, numbers =413; Dec 05 ATV=52, numbers=273; Jan 06 ATV=55.5 numbers=327). The ATV and productivity of veterinary surgeon A was able to be maintained with a significant reduction in stress and fatigue levels.

The change of veterinary surgeons, at the beginning and at the end of the period of this research, was significant. When new veterinary surgeons arrive and others leave, there were changes of faces that the clients saw, some who they had got used to, and new ones to get to know. The veterinary surgeons had to take some time to learn the practice systems, and to learn consultation skills from their new position in the practice, and also the practice had to deal with the issues of induction and training in consultation skills. The ATV for veterinary surgeon D dropped to only £40.79 in May 2006 from a previous ATV ranging from £50 to £62. This was partly due to the promotion of free of charge senior clinics. When veterinary surgeon D had been in the practice for her first few months, personal ATV was £43.76 to £48.53 during the period September to November 2004. This was also significant because the overall personal turnover for veterinary surgeon D who was seeing a high number of clients had a big impact on the overall gross turnover of the team.

Another key performance indicator that improved was the reduction in numbers of complaints from clients to practically zero, with just the very occasional complaint asking 'why should they pay?' Before the beginning of the programme, the

complaints were much more complex and time consuming to deal with, and much more frequent, (sometimes 3 a week).

Some links between consultation skills and KPI's emerged:

Behaviour of clinician	Consultation Skill	Key Performance Indicators	Best Link to KPI
Charging incorrectly for consultations	Perception of value and worth of the professional consultation	ATV, Gross Tnvr, Nos of 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> and other consultations	Numbers of 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> and other consultations
Static level of performance	Ability to reflect and evaluate own consultations	Growth in ATV, reduction in nos complaints	Attendance at 'in house training/development group', reflections and participation in the meetings.
Weak recommendation of a product or service	Poor perception of worth; imbalance of clinical interests for a GP.	Numbers of products or services supplied.	Numbers of products or services supplied by individual vet; vaccination and service ratios.
Zero recommendation of a product or service	Lack of knowledge	Numbers of products or services supplied.	Poor attendance at practice meetings and training/cpd events.
Strong recommendation of a product or service	Enthusiasm and training in products and services combined with ability to explain them to clients.	Numbers of products of services supplied.	Numbers of products and services supplied. RIAS from audiotapes.
Use of nurse to achieve best time management	Partly depends on vet perception of nurse capability; good working relationships with the nursing team.	Training management of the nurses.	Numbers of nurse clinics; numbers of vet referrals to nursing team. Identifiable hours spent training the nurses.
Time Management	Abilities to prioritise, triage, and organise time for further diagnostic workups and treatments.	Keeping to time with appointment list.	Feedback from receptionists and clients on time keeping.
Bonding of clients to the individual vet	Building a good rapport	Numbers of clients/transactions per month for individual vet	Take care to look at willingness versus unwillingness to share clients with other team members
Bonding of clients to the practice	Team play	Effective use of other team members and sharing the work to achieve the most effective outcome.	Numbers of clients seen per month in the whole practice
Response to request for, or self initiated written reflections on 'how did the vet change their consultations as a result of learning?'	Reflection	Obtaining written reflections by the Principal vet or managing partner.	A direct link to performance and the interpretation of performance figures provided a no-blame culture exists.

There was a relationship between some of the KPI's, which was illustrated by increasing ATV's for the nurses and the receptionists during the period of the research.

Receptionists' ATV's.

<b>May 2004</b>	<b>May 2005</b>	<b>May 2006</b>
15.58	20.67	24.05

Nurses' ATV's.

<b>May 2004</b>	<b>May 2005</b>	<b>May 2006</b>
15.40	24.50	26.87

Numbers of nurse clinics were rising as the nurses developed their clinics, which were mostly free of professional fees, but charging for products sold. There was also a rise in the numbers of clinics for which the nurses did charge a professional fee, including claw clipping, bandage changes and other clinical work. The practice aimed to encourage the nurses to do the jobs they were capable of within the rules governing veterinary practice, thereby relieving the veterinary surgeons of some tasks and saving the clients and the practice costs of professional veterinary surgeons time. These were important dynamics in the background to analysing the data for the veterinary consultations. The management of the practice took account of this in aiming to improve the efficiency and time effectiveness of the whole team.

Nurse clinics.

	<b>May 04</b>	<b>May 05</b>	<b>May 06</b>	<b>June 06</b>
<b>Nurse clinics priced</b>	8	26	42	29
<b>Nurse clinics free of professional fee</b>	150	153	140	230

The numbers of weight clinics done by the nurses related to the sales of obesity diets. The numbers dropped during the beginning of the period of research, but rose again during and particularly in the last 6 months of the period of research as the nurses acquired more enthusiasm and skill in running these clinics.

A finding was that measuring ATV's was linked to the output of each of the veterinary surgeons in both the consulting room and the operating areas of the

practice. The output from the consulting room was critical to delivering numbers of cases for the operating areas, including surgical operations, radiography and imaging, dentistry, (commonly known as ‘back of house procedures’). It was critical to the evaluation of consultation skills that the bias of varying skill and enthusiasm in the ‘back of house’ procedures was taken into account. However, it was not possible to find the individual veterinary surgeons ATV from the consulting room alone from the practice management software. This was found to be similar in other computer systems. This point made the need for audiotape analysis appear more critical.

Key performance indicators were sometimes confusing, and needed a qualitative approach to produce a plausible explanation. For example, the % dogs sold a prescription diet was higher than for cats. (Approx 28% for dogs, and 18% for cats : see tables of results). The volume of sales of prescription diets for dogs was higher than for cats. (See table of results. Approximately £10,000 to £11,000 per month purchased from one manufacturer for cats. Approximately £13,000 to £16,000 per month for dogs). This indicated a similar level of compliance with dog and cat owners. The practice sales of life stage diets for cats were much higher than for dogs. The reasons for this go beyond the scope of this research project, but further exploration of the possible reasons for similarity or variance in concordance has the potential for a big impact on both the delivery of best medicine and the financial performance of the practice. The researcher’s perception at the beginning of the research project as one of the clinician’s involved in this ethnographic work, was that there would be a higher compliance with cat owners than dog owners. This was partly due to the focus on the higher sales of feline life stage diets in the practice, which may have encouraged the view that cat owners were more likely to want to purchase a high quality diet from their veterinary surgeon than dog owners. This appeared not to be the case when the veterinary surgeon had identified a medical condition for which there was a need to recommend a special diet.

The strength of recommendation made by the individual veterinary surgeons for any one given product or service was likely to have a profound effect on the uptake of



those products and services. A very high percentage of clients were ready to listen to their vet, and valued that advice highly (This was found by client questionnaire in the focus group and also post consultation interviews in the visits to practices).

It was curious to note that in spite of having had training group meetings on the need for strong recommendation and charging correctly, the numbers of dentals dropped in May 2006 with the introduction of ‘vouchers to incentivise clients from senior pet clinics’. This emphasised the importance of the strength of the recommendation made by the veterinary surgeon over and above the financial incentives for the client and the removal of ‘veterinary surgeon perception of high prices’. The same result occurred with the discussions about ultrasounds, which also dropped in May 2006. At least one ultrasound investigation of a heart in a cat was done after recommendation for a ‘heart work up’ and not charged for at all. (16.6.06). Some reflection was sought from the veterinary surgeon team to explain this, after a powerpoint presentation was made to the whole practice team in which the numbers of dentals were included. (7.6.06.)

	<b>Jan 06</b>	<b>Feb 06</b>	<b>Mar 06</b>	<b>Apr 06</b>	<b>May 06</b>	<b>June 06</b>	<b>July 06</b>
<b>Dentals</b>	28	15	25	15	7	14	
<b>Ultrasounds</b>	12	11	17	15	15	12.5	
<b>Senior pet clinic voucher dentals</b>	0	3	7	8	0	1	
<b>Senior pet clinic voucher ultrasounds</b>	0	1	1	0	0	0	
<b>Nos invites to senior clinics</b>	80	250	151	0	0	0	
<b>Nos senior clinics done</b>	0	37	50	20	8	5	
<b>Nos invites to junior clinics</b>	0	0	0	0	0	270	5
<b>Nos junior clinics done</b>	0	0	0	0	17	54	8

The management style of the Principal veterinary surgeon who was also the worker researcher was influenced by this project. The veterinary surgeons were given

freedom to discover how they might improve, rather than being told how to do a job in a certain way. This did involve some risk for the business, but it did have the potential to discover what the veterinary surgeons really thought and why they consulted in ways of their choosing. It also had the potential for both the practice and the veterinary surgeons to realise a greater potential than from a dictatorial approach.

The researcher felt that it was important for each individual veterinary surgeon to take responsibility for their own self analysis of their own consultations and reflection on this, in order to understand how the vets' actions in the consultations were aligned with the vets' own perceptions of success. Veterinary surgeon F made the most progress during the period of study, and the researcher felt this was due to this vet's development across a broad range of interests, including the actual output from the consulting room in which the sales of wormers and flea products were high. Veterinary surgeon D improved during the period of study, but the range of interests was narrower with more emphasis on the surgical operations and back of house work. This reflected initially in the increase in ATV for veterinary surgeon D as the confidence and skill increased in the surgical areas and veterinary surgeon D was doing more of this work than the other vets. However, as the other veterinary surgeons gradually improved their surgical skills and a more even distribution of work and income generated from the operations was happening, veterinary surgeon D's performance in ATV was highlighted as having less actual output from the consulting room itself. This was also a critical point because one veterinary surgeon could do a large proportion of the operating/back of house work, but if the whole team was not recommending procedures strongly, the whole team performance was weakened significantly.

The development of protocols within the veterinary surgeon team was part of this group activity. Delegation to the team produced a slow output of protocols, but the junior and senior clinics developed excellent protocols and procedures, which really made a difference. A key point of resistance to the implementation of clinical protocols for following best practice was the repeatedly stated comment 'I don't think

the clients will all be able to afford these protocols.’ This came back to the meetings where dealing with money and clients who said they had no money, how best to recommend a service and explain it to clients, and showed that these meetings were still not really showing the veterinary surgeons the real links between consultation skills and outcomes. I concluded that often the veterinary surgeons were still thinking pre 1974 (Ref: Svarstad) when doctors thought the problems with being able to deliver good medicine lay with the patient/client.

Over a period of 15 years working in the practice (established 20 years previously (1986) a manual was developed for the vets. This had been approached from several different angles :

- First attempts were to give veterinary surgeons a free rein.
- Second attempt was to give them a manual/guide/protocols, which many ignored but overall improved.
- Third attempt was to get the veterinary surgeons to write their own protocols and discuss amongst themselves, which was slightly different from attempt 2 because I was taking a step back from the discussions involved in producing them. This resulted in some good protocols and implementation for the junior and senior clinics, but some drop in fee charging.
- Fourth attempt will now be for the Principal veterinary surgeon to revisit the manual and introduce more protocols from the collection that has built up and add some to hopefully make the most impact.

The research in the training group allowed the veterinary surgeons ‘clinical freedom’ and freedom of choice and expression (as far as was possible). It did seem that the veterinary surgeons applied themselves weakly to areas that they were not comfortable with. Some of these areas were critical for the practice such as

observation of fee charging policy and health and safety policies. Whilst the research enabled the true approach of the veterinary surgeons to be identified, and their true feelings to be identified, a more common approach from the management point of view has been to enforce rules of fee charging and health and safety. However, this approach can lead to the same behaviours being repeated, even when disciplinary procedures are initiated.

The question of whether or not do prescriptive procedures make a difference and by how much, was an area for further development beyond this project.

Reflections were obtained from 2 of the veterinary surgeons and the worker researcher (Appendix 3). This was a very useful part of the learning and development cycle. This indicated that points had been useful in the training and received some thought. This was a particularly positive outcome because it had been difficult to obtain feedback from veterinary surgeons in practice about what they really think, both in the experience of the researcher and other veterinary surgeons in discussions at conferences.

#### ***4.F: Visits to Practices.***

One of the most important findings in my visits to practices was that the veterinary surgeons felt very sensitive about this, and often felt they were being observed to assess them, which they feared. However, the opportunities for analysing the consultations, and learning from the analysis, was a more attractive proposition to them.

##### **4.F.1. Analysis of interactive seminars in visits to practices.**

There was a basis for understanding where things have got to in the proceedings dated November 2002 of a meeting (LTSN workshop) in which the University Veterinary Schools discussed consultation skills and their teaching. Things have moved on quite a bit since then, but a quote from one of the practices I recently visited could equally well be applied as a comment to this report. The final year student participated in the interactive seminar with all the veterinary surgeons in the practice in which we discussed 'the definition of a successful consultation.' It didn't take the veterinary surgeons long to produce most of the components of the Calgary Cambridge technique, although they didn't know it was called that. They produced more than the Calgary Technique and the student from Liverpool said:

'Well it looks like most of what we have been taught is on the flip chart, with the one exception of 'time management.'" (Ref: Practice 'S'.)

In practice, this is a BIG component of what we actually do in a consultation.

Here is a summation of the views of the practices on what was important in the success of a consultation from the interactive seminars in the practice visits:

Paul R. Manning project report

Success		Practice 1 (A)	2 (S)	3 (W.E.)	4 (W)	5 (C)	6 (P)	Total
Greeting	Chat, rapport	/	/		/	/		4
Question type	open				/	/		2
listen			/			/		2
Vet likes animal	Pet likes vet		/			/		2
Clin exam	Attention to animal			/	/	/		3
Sift information	From chat		/			/	/	3
Time management		/	/		/	/		4
CARING	INCLUDES ASPECTS OF ALL OF THIS.							N/a
Good explanation			/			/	/	3
Good estimate	Of costs		/			/		2
Eye contact, body language	handshake		/	/	/	/		4
Compliment client		/	/					2
Supportive advice		/						1
Simple, concise, summarise 3 pieces of information for client		/	/		/		/	4
Owner understands problem fully		/		/				2
Owner understands how to improve the problem		/		/		/		3
Owner is motivated	To improve the problem			/	/	/		3
Vet recommends for the animal		/		/	Lots of constraints	/	/	4
Nurse referral by vet		/			Not used			1
compliance		/				/		2
Fulfil client needs	Happy client	/	/		/	/		4
Exceed client needs	Telephone support	/	/					2
Happy junior partner			/					1

Happy senior partner			/					1
Perceived value by client	Bill paid	/	/					2
Client recommends practice afterwards	Practice surveys this		/					1
Size of bill		/	/					2
Expected clinical outcome anticipated			/					1
Book a revisit			/	/		/		3

There were some components of the definitions, which were quoted in the same way in more than one practice, some that were similar, and some that were only mentioned by one practice.

#### **4.F.2. Constraints to achieving success in consultations.**

The veterinary surgeons also referred to the constraints on their ability to achieve the success they strove for. These included:

- time management
- client perception of cost in today's socio-political environment
- less well off clients are not less likely to want to spend money on their pets but values are important
- the image of the veterinary healthcare professional was considered very important by one practice
- fear of rejection was considered important and also interesting; i.e. veterinary surgeons were aware (sometimes less consciously than either other veterinary surgeons or at certain times) that they feared their advice and recommendations might be rejected, and the veterinary surgeons said this had an impact on what and how they recommended products and services



#### **4.F.3. Analysis of transcripts of audiotapes.**

Transcribing and analysing the tapes of the consultations was interesting in that the word linkages, pauses, specific use or absence of a word or words in the speech, could be analysed and compared to outcomes. However, this may not take account of the factors impacting on the consultation. Consideration was given to conversation analysis' (CA) whereby groups of meanings are extracted from the audiotape. (Silverman, D., 2001).

'Without a way of defining a research problem, even detailed transcription can be merely empty technique'. (Silverman, D., 2001). This finding was also what emerged in this Doctorate research as the definition of the problem first became clear, and then became challenged again as the detail was worked out in the preparation and the conducting of the listening to and analysing the audiotapes.

Observation of the consultation and the analysis by interviews of the client and veterinary surgeon afterwards are very important to the interpretation of the transfer of information in the consultation. The contribution that the analysis of the audiotape can make was in the interpretation of the value of the relative use or absence of :

- words
- dialogue
- types of questions
- interruptions
- time spent both in the consultation and in the relative proportion of client and veterinary surgeon speaking during the consultation
- comparison of the above between different types of consultation ; ATV preventive medicine, oncology, cardiology, dermatology, surgical cases
- Percentage of consultations in which a recheck or follow up is arranged

The approach taken to the analysis of the audiotapes was to follow the procedure described by Roter, then tabulate the data (Appendix 8), and then to integrate the findings of RIAS with a commentary critiquing the consultations.

The quality of the tapes was recorded as

- complete or incomplete (e.g. if the immediate opening greeting had been missed)
- good or poor quality of sound.

#### **4.F.4. Results of the RIAS analysis of the audiotapes.**

RIAS was a research instrument used to identify which consultation skills were being used by the vets.

The coder in this research was the researcher who had no prior knowledge or experience in the use of this method of analysis. The numbers of remarks counted by the researcher were generally much lower than those reported in the literature (Shaw, 2004), but the same coder analysed all of the audiotapes, which allowed comparisons to be made. The coder found some difficulty in recording numbers of remarks during a long piece of conversation in which one category of remark was being expressed. For example, a long series of sentences in which a veterinary surgeon was giving medical information might have scored less points than in coded consultations reported in the literature, but the same issues and bias was applied by the same coder to all of the consultations that were analysed in this research project.

The broad picture from these tabulated results (Appendix 8) was that there was mostly a predominance of questions being asked by the veterinary surgeon compared to the client, and there was a good 'giving and sharing of information about the medical condition and therapeutic regimen' between the veterinary surgeon and the client. There was hardly any mention of diet.

- The number of client utterances was linked to numbers of open questions, but not to the length of the consultation
- The numbers of closed questions increased in relation to the shorter time of the consultation
- Good use of time included use of listening to the client as measured by the number of client comments in the RIAS, and also the number of open questions
- RIAS did not take account of the sharpness of the communication, so short but very clear utterances could be unjustly compared to a series of many

utterances, which did not represent success in providing the client with understanding

In one consultation, the reason for the client being there was not established, and so the vet's understanding of the client's requirements for vaccination was incorrect. In this consultation, there was a lot of exchange of personal remarks and 'chat', but hardly any exchange of information about medicine or treatment.

The number of open questions was low compared to the number of closed questions used by the vets, and this was more apparent when the consultations were shorter in time, particularly when only 7.5 minutes.

The exchange of information on the medical condition and the treatment regime increased with length of consultation, but the discussion of the diet remained low and largely unchanged.

More client information on the medical condition was associated with higher numbers of open questions.

Table illustrating numbers of remarks exchanged expressed as totals of client and veterinary surgeon remarks added together.

<b>Length of consultation Nos of consultations analysed</b>	<b>Nos of personal remarks and laughs :average</b>	<b>Medical questions: open :average</b>	<b>Medical questions: closed :average</b>	<b>Medical information given :average</b>
7.5 minutes:6	10:1.7	12:2	18:3	63:10.5
10 minutes:15	99:6.6	26:1.7	35:2.3	129:8.6
15 minutes:5	22:4.4	5:1	37:7.4	72:14.4
45 minutes:1	1:1	5:5	15:15	60:60

Table illustrating numbers of remarks exchanged expressed as totals of client and veterinary surgeon remarks added together in the vaccination consultations.

This table includes a consultation where the second part of the consultation was a vaccination, so the personal remarks and laughs have been included when uttered in the first half of the consultation.

<b>Length of consultation Nos of consultations Analysed</b>	<b>Nos of personal remarks and laughs :average</b>	<b>Medical questions: open :average</b>	<b>Medical questions: closed :average</b>	<b>Medical information given :average</b>
7.5 minutes:				
10 minutes:7	51:7.3	6:0.9	15:2.1	47:6.7
15 minutes:1	6:6	2:2	11:11	17:17
45 minutes:				

An example from the actual analysis of the audiotapes in one practice was that a client in the consultation (Appendix 8 :RIAS C c3) actually asked the veterinary surgeon for a recommendation for a wormer for her pet, and strengthened that request by saying she wanted the ‘best for her pet and the people including her grandchildren’, and yet the veterinary surgeon said ‘I am supposed to recommend a wormer once a month, but it’s up to you really.’

The analysis of the tapes did enable the strength of the recommendations to be assessed. One example of this was when a veterinary surgeon in a 7 minute consultation recommended a flea and worm product three times, simply repeating the same words recommending the product. The first words elicited a question from the client who asked firstly why, and then secondly was it really worth it because he didn’t think he could afford it? The veterinary surgeon used the same words to recommend the product on each of the three consecutive occasions, so on the RIAS scale would score ‘giving information about the treatment’ three times, or possibly repetition of the information given about the treatment. However, the observation was that the quality of the remarks and response to the client’s questions were very poor.

#### ***4.G. Analysis of observations and semi structured interviews in visits to practices.***

The observations and interviews were closely linked, and made more sense when considered together than in isolation. This was partly because the observations sometimes made the interview questions obsolete, but sometimes the interview helped to clarify client understanding.

It was difficult to hear and audiotape the consultations which were done in a room partly divided by a wall, but in which 2 consultations were being done at the same time. This was because considerable concentration was required to hear the individual conversations above the simultaneous consultation. However, in all of the other observed consultations there were no obstacles to the observations. In many interviews, there was a separate room to conduct this part of the research, separate from the consultation room in which another unobserved consultation was being done to ensure good time keeping for the participating practice. In some practice situations the interview was carried out in the consulting room in between consultations where the practice had very kindly made this arrangement to accommodate the researcher, or sometimes the interview was carried out in a corner of the waiting room. All of these situations worked well, although the quiet atmosphere in a separate room was most conducive to a relaxed mode of interviewing with no distractions or time pressures. In the waiting room, sometimes the distractions for the client and the interviewer included other activities going on around the interview such as dogs barking, and also sometimes the interviewer felt that the client wanted to get the interview over quickly in order to get the dog or cat back into the car.

The following table shows in how many consultations observed where interviews took place, there was agreement or understanding between the client and the vet.

Agreement/ understanding	What problem?	Name of condition	Treat ment	Prognosis	Care Score	Commonest reason for care score
7 minute consultation (7 observed with follow up interviews)	7	6	7	5	OK(not scored on the Likert scale)	Explained; got all the information required; Understood.
10 minute consultation (14 observed with follow up interviews)	13	12	13	12	average for client average for vet In every score where the vet and the client scored the consultation, the vet scored themselves lower than the client.	Very good, checked for owner's concerns, really nice and friendly, puts the dog first, spends time, patient
15 minute consultation (5 observed with follow up interviews)	5	5	5	4	4.8 average for client average for vet. In every score where the vet and the client scored the consultation, the vet scored themselves lower than the client.	Willing to help client wash the foot or dematt, learned a lot, professional advice, reassuring
45 minute consultation (3 observed with follow up interviews)	3	2	3	3	4.83 average for client 4.0 average for vet. In every score where the vet and the client scored the consultation, the vet scored themselves lower than the client	Client judges on outcome, knew what he was talking About, owner liked to be involved in the decision making, list of options.

The 7 minute consultations tended to be very focussed on the time available with more use of closed questions by the vet. There was less time for social chat, but the directions given to the clients at the end of the consultation were often spelled out very clearly by the veterinary surgeon to the client, but this had less opportunity for clients to ask questions and express their concerns. The interviews showed that the clients had no more questions to ask when asked the direct and rather closed question 'did you have any concerns or questions you wanted to ask?' or 'did you feel that all of your questions were answered by the vet?' the clients responded 'no, I think the vet explained everything'.

The 10 and 15 minute consultations usually had more time for social chat, and open questions and more interaction than the 7 minute consultations. The use of the time tended to vary with how well the client and the veterinary surgeon knew each other. There was more social chat when the client and veterinary surgeon had known each other well and had seen each other on previous consultations, but also there was more reference to previous consultations and previous case history which sometimes involved mention of things that happened years ago which both the veterinary surgeon and the client were aware of.

The 45 minute consultations tended to involve much more detail in the history taking, with the use of open and closed questions by the veterinary surgeon probing the detailed medical information during and before the medical condition developed. This was a referral situation in which an RCVS Specialist was doing the consultations, and so previous knowledge of the client on a personal level was normally not apparent. However, previous knowledge of the referring veterinary surgeon was clear, and strenuous efforts were made to ensure that the relationship between the client and the GP veterinary surgeon were understood. This included the use of questions by the veterinary surgeon asking the client about the previous treatment and diagnostic tests from the GP vet.

The understanding between the client and the veterinary surgeon was demonstrated in nearly all of the consultations observed from the results of the interviews. There was a high level of understanding between the client and the vet, who agreed on what the problem was, the name of the condition, and the treatment. There were a small number of consultations in which the prognosis was not clearly explained or understood. The researcher was trying to establish whether or not a prognosis was possible in the circumstances, and whether or not the veterinary surgeon had explained this and the client had understood it. The high level of agreement of understanding was consistent throughout the 7,10,15 and 45 minute consultation lengths.



There was a lot of agreement by the clients that they thought their veterinary surgeons were very good, and they scored the veterinary surgeons nearly always 4 or 5 out of 5 on a Likert scale, 5 being the best they could have been. However, the reasons given for the score of 'how well the veterinary surgeon cared for the client and the animal' produced some interesting comparisons between the various lengths of consultation. The 7 minute consultations were very focussed with a tendency for short exchanges between the veterinary surgeon and client. This may have influenced the simplicity of the responses from the clients in the interviews, in which the researcher found that it was difficult to relax the client. This was also partly due to the necessity to conduct the interview in a waiting room, which was often busy, whereas in other practices there was often a more relaxed atmosphere coupled with the facility of a separate and quiet room, which facilitated a more open interview. With these points in mind as to possible bias, the results showed that the client feedback from the 7 minute consultations was short and simple, including remarks such as 'explained', 'got all the information required', 'understood', 'was not important for me (client) to know.' The client feedback from the 10 minute consultations done in 3 different practices, (See C,S,A in the tables), was much more effusive and complimentary. Comments included 'excellent, talks easily, not arrogant', 'good approach, patient, nice person, good knowledge', 'impressed by attention to detail', 'brilliant care, 110% animal lovers, make you feel you're an individual, helpful staff', 'good examination, checked for owner's concerns, friendly,' 'brilliant man, helpful, trustworthy, spends time'. The 15 minute consultations done in one practice, (Ref: W in the tables), also produced very complimentary feedback including 'learned a lot, professional advice, reassuring, particularly helpful on diet although no specific diet recommended', 'willing to help the client dematt the cat or shave the dog's foot which the client could not do at home.' The 45 minute consultations done in 1 practice, (See W in the tables), included a significantly larger amount of detail in the client responses and depth of understanding.

The practice in which the client appreciated the extra jobs the veterinary surgeons do in the consultation such as shaving the matted fur or cleaning the dog's feet had a policy revealed in the seminar that they don't use nurses in consultations and do not run nurse clinics. Discussions followed in the evening after the afternoon spent observing the consultations and recording them. One question raised was 'would the practice be better off employing a nurse and charging for her services instead of having 15 minute veterinary surgeon consultations, or at least considering a combination of the two?' One of the senior veterinary surgeons had a perception that the practice had grown from a farm animal base, and the small animal side was seen as a 'little project to support the farm animal interest.' Also, the cost of training veterinary nurses was seen as a major obstacle.

It was interesting to note that the word 'friendly' appeared in all of the feedback from clients except from the 7 minute consultations.

### **Key objective of the interviews.**

A key objective of the interviews was to discover what the client had understood from the consultation and the difference in any perceptions the client may have had from the veterinary surgeon in what was communicated. This led to the question number 5 (how well did your veterinary surgeon care for you and your pet) being identified as the one question about which the client appeared to be more of an expert than the vet. This was natural and true because the client was the only one who could truly understand what was being understood in their mind. There was some similarity in this with question number 1 (what was the problem?) because in this question also the client had the knowledge of what the presenting signs and history were, and the veterinary surgeon had to try to ascertain what those facts were. The diagnosis and the name of the diagnosis, the treatment and prognosis, were all in the hands of the veterinary surgeon as the expert because the veterinary surgeon had to explain what each of these components of the consultation involved. This meant that it was relatively easy to obtain the understanding and perception of the client for questions 1

and 5, but the questions 2,3 and 4 required a more 'teacher-pupil' relationship in which the client was often feeling they were being tested on their knowledge retention and memory rather than being on an equal or advantageous position of greater knowledge.

One client in a 7 minute consultation had not been given any information on what diseases the dog was being vaccinated against, but the client said in the interview that 'she did not need to know.' A client in a 10 minute consultation had forgotten what the interviewer/researcher told her the dog was vaccinated against within 2 minutes of being questioned again, so there is a limit to what clients can understand and remember. However, there were aspects of the consultation, which were important for the veterinary surgeon to understand about the client needs, and this important aspect was eliciting client concerns and finding out what the client wants to know about the vaccination or other reason why they are attending the vet.

One example of this was one (Appendix 8: RIAS S C3) in which the social chat dominated the whole consultation, and the veterinary surgeon did not really find out why the client was there because the client did not explain that she was there because her dog needed a vaccination in order to go into boarding kennels while the owner was on holiday, and the veterinary surgeon did not ask specifically 'why have you come to see me today?' The result was that the needs of the client and the pet were not met. This was also an example of a disadvantage of the veterinary surgeon and client knowing each other very well and for many years, because that was a reason why the veterinary surgeon and the client spent so much of the time in the consultation in social conversation.

During the interview with this client (Appendix 8: RIAS S C3), the client expressed the opinion that 'since a senior partner had left the practice, there seemed to be much more emphasis on doing as much as the veterinary surgeons could for the animals which raised the costs involved, and on one occasion the lady had asked for more explanation for the need for the additional blood tests.'

An advantage of the client and veterinary surgeon knowing each other well was the trust they had between each other, and this enabled more conversation and questions being asked by both the client and the veterinary surgeon that really probed the issues and concerns in an open and relaxed way. The questions were sometimes more structured or 'stiff' when the client and veterinary surgeon did not know each other. There were advantages in knowing the client well in that the client tended to volunteer the case history with a lot of very relevant and useful information in a short space of time. Clients felt their veterinary surgeon listened well to them if they knew them well, although this was also partly a result of 'long term selection of the veterinary surgeon by the client who had worked out their preferences for their choice of vet.'

There was considerable satisfaction expressed by clients in interviews in various practices, but an area that would merit further research would be the client satisfaction level when the vets' perception of optimal service had been delivered. It was interesting that in this example the client had scored the veterinary surgeon very highly, until she discovered and became aware that her needs and those of her pet (namely to receive a kennel cough vaccine to enable her to go on holiday and leave the dog in a boarding kennels) were not met on the first attempt. Communication via the receptionist enabled the situation to be rectified.

This same client (Appendix 8 : RIAS S C3) also stressed she wanted the best for her pets, and so it seemed that as long as a good explanation was given, this client and many others who were interviewed would have been very happy for the veterinary surgeon to recommend and carry out diagnosis and treatment of the pet in the best interests of the pet and the owner-companion animal relationship.

One example of where the veterinary surgeon and the client were both appreciative of the limitations of the 'environmental conditions' of the consultation was in practice 'A' where the veterinary surgeon and the client both commented on the 10 minute waiting time which both appreciated had contributed to the dog becoming

overanxious. This was a good example of how a balance of concern was achieved without the client blaming the veterinary surgeon for the conditions surrounding the consultation.

One finding was that in one practice the senior veterinary surgeon spent more time listening to the client than his younger colleagues, and yet his clients always felt he had more time for them. He managed to stick to his schedule of consultations whereas his younger colleagues who interrupted clients earlier and used more closed questions tended to be less successful in meeting the client needs and in keeping to their schedule. (See analysis of the audiotapes also.) The personal gross turnover figures for each individual veterinary surgeon were strongly disliked by one of the vets, thought to be divisive, and were not used in the practice to discuss performance with the veterinary surgeon team. However, the veterinary surgeon who's clients felt he listened and always took time with them, and also was observed to allow time for the client to tell him their concerns at the beginning of the consultation, did have the highest personal gross turnover.

Vet	Gross annual personal turnover
S	£111,000
J	£126,000
C	£147,000
R	£161,000
D	£172,000

- Veterinary surgeons scored zero in issuing a written results of routine annual health check for vaccination: audiotape analysis confirms lack of recommendation of need for annual booster vaccination.
- Euthanasia consultation produced a lot of engaging discussion between veterinary surgeon and client.

- Very simple recommendations made by the veterinary surgeon only once were successful and accepted by the client. Sometimes a simple explanation to a client's question was all that was required to strengthen the recommendation.

The interviews tended to reveal that the veterinary surgeons' perceptions of the consultation were less in quality of care on a Likert scale 1-5 than perceived by the clients. The reasons the veterinary surgeons tended to give for scoring themselves lower usually included either their feeling that what they did was not important, (but to the client it was perceived as very important and appreciated), or that they felt they should have recommended a procedure or product more strongly but did not. It would appear that veterinary surgeons involved with primary health care in general practice need to put a higher value on what they do to match their client's perceptions and expectations. The question 'does a higher assessed value of consultation result in a higher volume of veterinary healthcare delivery?' seemed to have been answered by this project with a positive. Whether or not a high actual assessed value of veterinary consultation associated with a higher market price would result in a greater uptake of volume and quality of veterinary healthcare services was beyond the scope of this doctorate research project, but it could be important in the future.

***4.H. Dissemination and testing of the research with a wider audience.***

Some key questions were explored with a wider audience. These included the exploration of what veterinary surgeons considered to be a successful consultation.

#### **4.H.1. Seminars and SPVS Roadshow in Consultation Skills.**

These activities served two purposes. Firstly, they provided some opportunities to explore the skills and interest in the wider veterinary community, in groups of widely varying age, experience and geographical distribution. Secondly, they provided a medium through which the newly emerging concepts could be disseminated and tested.

The programme planning for the SPVS day in January 2006 included the view from the University, the view from practice, the commercial companies and finally how the medics have developed their consultations. 30 delegates came to the event. This was a good number for achieving effectiveness in the small workshop discussion groups.

It was very clear from the presentations and from the delegates, that there were many similarities facing doctors and veterinary surgeons in their consultations. Many similarities in the required skills were identified, but there were some differences in how pet owners 'open up' to their veterinary surgeon compared to how human patients reveal their concerns to their doctors. Eliciting client concerns was considered important, and the processes in the consultation were also highlighted.

Many pressures and challenges were identified on the day. The clinician brings a lot of 'baggage' with them to the consultation (presentation by Paul Manning). This can include worries from domestic life, money, management workload, political interference, ethical issues and many more. The statistic (quoted by PetPlan) that doctors are trusted by just 2 percentage points less than veterinary surgeons in a survey did not really mean that veterinary surgeons were somehow 'superior to doctors', but that the challenges were slightly different. However, the trust that veterinary surgeons enjoy had big advantages in eliciting client concerns, which meant that the veterinary clinicians could do a good job more of the time as long as they actually did a good consultation. The issues of money and affordability of veterinary surgeon fees were raised, and this made the importance of the consultation



skills increasingly and sometimes now critically important for vets. The challenges the doctors have faced with the running of the Health Service and issues of trust for 3 decades have stimulated medical colleagues to work very hard at finding solutions to developing better consultation skills. That experience is proving to be invaluable to the veterinary profession as new challenges are met in the marketplace. Feedback from delegates showed that considerable benefit was derived from attending the day.

#### **4.H.1.1. Analysis of findings.**

The analysis of the workshops included research investigating the definition of what a successful consultation looked like in a wider audience of vets. There were common findings in this from the workshops in the SPVS Roadshow, Veterinary Christian Fellowship annual conference, and the Hills Practice Health Symposium.

It was likely that the definition of Key Performance Indicators (KPI's) would be derived from these workshops. There were some practices and veterinary surgeons who felt the definitions of success did include some KPI's commonly used in practice management, and some points, which were not commonly included.

#### **4.H.1.2. Outcomes from the SPVS Roadshow.**

Delegates gave very high praise for the event, and clearly found it interesting, stimulating and enjoyable. This was important feedback because the subject matter had not formally been on the Veterinary postgraduate cpd agenda before, and many 'non-clinical cpd events' had proved difficult to attract veterinary surgeon delegates.

Feedback following the event from at least one delegate illustrated how the learning from the day had been assimilated, reflected upon, and implemented in changing a practice approach to consultations. One delegate wrote some excellent reflections, which he took back to his practice, and then started to develop the material in veterinary surgeon team meetings in a proactive way. This was an excellent example from an experienced practitioner, who appeared to be further into the learning cycle than the veterinary surgeons in my own practice Learning Set. It seems likely that there is a certain level of experience and awareness that veterinary surgeons need before they appreciate the real importance of good consultation skills. This precedes their own personal development of these skills, and their ability to implement them and then reflect on the outcomes of the changes they choose to affect their own consultations.

One comment in the feedback from delegates was 'Dr Mei Ling Denney provided the only insight into how to improve consultation skills.' This highlighted the difficulty of getting the message across about the theory and making this interesting, so that delegates could then see the reasons why consultation skills were important, and how they might set about analysing them. A key point that I tried to get across was that it was important to analyse consultation skills using various methods so that veterinary surgeons could then see their performance in useful ways, which would then motivate them to want to do something about improving their skills. Having a method of analysis and the results to compare should enable veterinary surgeons to choose the most appropriate skills to work on and improve. Having a choice of method of analysis should encourage more veterinary surgeons to commit to their choice to work

on their decision to improve their consultation skills by providing them with a selection of tools to use for this purpose. There was more development of this aspect that was being worked on and incomplete at the time the roadshow was done in January 2006, but these points were helpful in pursuing the research and creating a better follow up roadshow event in October 2006.

The potential for using this method of delivery of education and development in this key area of veterinary practice could also be realised in the development of a 'C' module in the new RCVS CertAVP due to be launched either late in 2006 or in 2007.

Compliance of 55% quoted from the AAHA survey compared very closely with some of the medical literature, which was quoted by Dr Mei Ling Denney. Mei Ling Denney said that about 50% of human patients do not take their tablets after visiting their doctor.

Two reports from delegates, one a Past President of SPVS, the other a future President of SPVS, were published (Lewis, K. 2006; Hill, J. 2006).

#### **4.H.2. Veterinary Christian Fellowship seminar : 'Caring in the Consultation'.**

This was an opportunity to explore some of the core values that veterinary surgeons express through defining a successful consultation, and to compare the findings from this group composed of veterinary students and graduates with a wide range of experience (0-28 years) in different types of practice.

The group felt that being a Christian should make no difference to what or how a consultation was done, but it should make a difference in why it was done. The group felt that they cared because they had a responsibility to care for God's Creation. They also felt they cared because clients care and have needs, and they also had a self-interest and a need for job satisfaction.

The group felt that care included empathy, understanding the music and feelings behind the words, taking time to explain after the clinical examination, and obtaining informed consent and agreement with the use of an appropriate signed form.

The group felt that their definition of a successful consultation included :

- Quickly and efficiently get to the point and address client concerns
- Precise or good working diagnosis
- Client is happy and confident in the veterinary surgeon and the advice
- Good explanation
- Options discussed
- Good time management, including use of nurses to help where appropriate
- Good management and support structure in the practice
- Good estimate of costs involved.

The group felt that components of how they achieved success included:

- Relating to their own dog or pet, especially in euthanasia. (RIAS category 'self disclosure')
- Encourage client over difficulties in giving tablets
- Use of good questions
- Open and closed questions
- Hello-history-exam-explain-recommend-summarise

Obstacles and constraints were felt to include:

- Money and costs
- Time pressures
- Relationships between humans and pets, which were considered to be unhealthy sometimes. Strong emotional attachments between ladies of senior years and their budgies were difficult to understand for some veterinary surgeons who have spent their lives working with farm animals

A report was published in the Newsletter of the Veterinary Christian Fellowship (Manning, 2005).

## Chapter 5. TRIANGULATION OF RESULTS.

Similarities were found in the evidence collected from the use of different research instruments, which supported the findings to the research questions.

This table contains a summary of this thesis relating to each research instrument.

Objective/research question	Research instrument	Research findings
Consultation skills : what are they and how can they be measured?	Literature search. Observation, interviews.	Several different models in the literature, compared well to different skills being used in the practices visited and the training group.
What do veterinary surgeons think a successful consultation looks like?	Meetings in practice visits. Training group. Interactive seminars.	There was considerable triangulation between the results of the use of different instruments. Rapport, time management, body language, simple summary with 3 pieces of information, vet recommends for the animal, client needs fulfilled were the points most commonly found in the different practices.
Do veterinary surgeons and practices use KPI's, and if so which ones?	Literature review, meetings in practice visits, training group.	Gross personal turnover per vet, ATV.
What links are there between consultation skills and KPI's?	Training group. Visits to practices, meetings. Observations, interviews with veterinary surgeons and clients. Literature review.	The ability to reflect, produce written reflections, is a key consultation skill with very powerful links to performance. This is very valuable in developing a cycle of learning and improving performance.
What methods of developing consultation skills for veterinary surgeons are the most effective?	Training group, Roadshow and seminars.	Monthly training group meetings, sharing data that was visually presented.
In what ways can consultation skills be encouraged to improve performance?	Literature search, training group, Roadshow.	Stimulate interest through monthly meetings, highlight variations in vet performance illustrated with graphs of figures, encourage veterinary surgeons to write reflections on their consultations.
Do veterinary surgeons associate consultation skills with caring? If so, what skills do they consider to be the most important, and do they think these skills can be measured?	Training group. Interactive seminar (VCF). Visits to practices. Interviews.	Yes they do. There were many similarities in the skills found to be important using the different instruments. Some skills were more easily measured than others.

<b>Objective/research question</b>	<b>Research instrument</b>	<b>Research findings</b>
In what ways do veterinary surgeons feel that successful outcomes are measured in KPI's?	Training group. Visits to practices.	Client satisfaction was strongly stated.
In what ways do veterinary surgeons feel that successful outcomes in delivery of care cannot be measured?	Training group.	Empathy is difficult to measure
What aspects of success in consultations can be linked to KPI's?	Observations. Interviews. Analysis of audiotapes (RIAS).	Good use of appropriate types of questions, well balanced use of time in sharing information about the medical condition and the treatment.
Is it possible to predict performance from analysis of consultation skills?	Training group. Observation and interviews. Analysis of audiotapes.  Collection of data from interactive seminars on the vets' definition of successful consultation.	Yes. Examples included inappropriate use of chat and questions leading to poor performance outcomes in visits to practices. Vets' definition of success did correspond with the results of the observations and analyses of the consultations.



## **Discussion.**

The literature review including the study of different models, the training group and visits to practices all supported the hypothesis that consultations vary in the complexity of the clinical aspects as well as the client concerns. Veterinary surgeons and clients also vary in the level of perceived care in the consultation.

The research questions comparing the effectiveness of different training methods were only explored through the practical experiences of doing monthly training groups, the seminars, and the full day's training event (SPVS Roadshow). There were issues that were beyond the scope of this project in the use of mentoring and coaching.

'Care was defined in the literature, the training group and visits to practices. Collins Dictionary defined care as 'to have concern and regard for, provide for physical needs, help and comfort.' The New Oxford Dictionary describes care as 'the provision of what is necessary for the health, welfare, maintenance and protection of someone or something.'

The observations and interviews also provided evidence of the definition of care in the consultation.

The seminar 'Caring in the consultation' supported the evidence gathered using the other research instruments.

It was possible to analyse the components of 'care in the consultation'. Patient-centred-ness helped to focus the concerns, which could lead to better provision for physical needs, more help and motivation for the client, and greater comfort for the client. There were examples of this in the literature search (Stewart 1974). Stewart also found links between measures of patient centred-ness in ability to ask questions that elicited client concerns and the success of the consultation.

RIAS helped to identify utterances, which linked to a greater number of client concerns being shared. One example was the failure of the veterinary surgeon to ask why the client was there, which resulted in the failure to meet the client and patient requirements for vaccination. This was observed, and the RIAS confirmed the consultation contained a preponderance of social conversation with hardly any exchange of medical information.

The practice in which consultations were 7 minutes duration, experienced 284 appointments in a single month in which clients did not arrive. This was much higher than the industry 'norm', and some shock was felt when discussing this figure both with the practice and other vets.. Links to this included low use of greeting at the beginning of the consultation, few open questions, but most clearly evidenced by the presence of no word 'friendly' in the client feedback from the post consultation interviews. The word 'friendly' did appear in the feedback from the other lengths of consultations (10, 15 and 45 minute) in this research.

This was an example of measurement of success or failure to achieve it. Assessment of the consultation skills by observations, interview and recording by audiotape with RIAS was limited by some difficulty in comparing the results with models of consultations which had been developed in the medical literature mainly for use with video recording. A strength of RIAS for audiotape analysis was that it could specifically identify the use of key words and phrases in specified categories. This was illustrated by the specific absence of greeting words in some consultations, and an absence of discussions or recommendations about diet in nearly all of the consultations observed in this research project.

**Table illustrating links between consultation skills and KPI's, and which research instruments provided the evidence for triangulation.**

Outcome	Links between consultation skills and KPI's	Triangulation of evidence
Client confusion	Reluctance or embarrassment to charge/ low average transaction values or missed opportunities for healthcare	Hawn (1997), Training Group, Practice visits.
Added value for client	ATV's for vets, nurses and receptionists.	Training Group, practice visits, Conferences (VPMA, SPVS, NAVC).
Achievement of success	Definition of success	Literature Search (Stewart, 1984 : patient centredness), Training Group, practice visits.
High numbers of appointments not kept by clients	Low use of greeting, open questions, absence of the word 'friendly' in client feedback.	Observations, interview feedback, RIAS.

The research produced good correlation in the answers to the question 'what did care look like in the consultation?' from the seminars in participating practices.

It was not possible to gain access to information about the consultations using only one method, because different veterinary surgeons had different fears about having their consultations analysed. The fear factors were found in the literature review, case study/ training group and the visits to practices.

The use of video recording was found to be prohibitively difficult to use in research in veterinary consultations during the time of this study, at a time when the veterinary profession were only just beginning to explore their consultations. This research instrument appeared to have the highest fear factor amongst the vets. Whilst it was acknowledged that the words in a consultation convey only a small part (7% according to some reports) of the total communication, it had to be accepted that it was not possible to collect data in this way during the limited period of the research. It was also found that a large part of the analysis of consultations in the medical field and literature was focussed on the words. Assessment of consultations was a large and complex area in its own right. The focus of this research was in exploring practical ways of analysing consultations that could have application to developing the skills linked to KPI's. The objective was to find links that could be utilised in practical and time and cost effective ways in practice. The use of video recording

could be explored once the veterinary profession becomes more accustomed to using this instrument.

There were some difficulties in finding links between observations and other findings from exploring the consultations. However, there were some links between the definitions of successful consultation found in the interactive seminars in individual practices, and the observations and RIAS. For example, practice 'P' had no greeting in their definition of successful consultation, and there were very few words of greeting in the observations and RIAS of these 7 minute consultations. The practice Principal Vet also said that 'they tell the clients what to do' in the definition of success, and this was seen in the data collected from observations and RIAS with some poor listening skills and poor responses to client concerns; eg: one client asked about flea treatment and the vet simply repeated that he should use the product without explaining why in 3 consecutive questions asked by the client during the consultation.

Some practices scored time management as a high priority, but did not always use the consultation skills effectively; eg: practice S did one consultation with a high percentage of chat, and several examples were found when the greeting and listening was very short at the beginning of the consultation. Two practices which did not mention time management as a priority were 'W' in which there were 15 minute consultations, and 'W.E.' in which there were 45 minute consultations. It seemed likely that these two practices had felt that they had addressed the issues of time management by choosing a longer consultation time and this was felt to be the best way of dealing with time management issues by these practitioners. It was important to appreciate this point when interpreting the evidence.

Some of the consultation skills were not difficult to understand or deliver, but the absence of some of the skills from the vets' individual definition could have been related to their absence of actual use. Good triangulation of the reasons why vets should use consultation skills were found in the literature search and in the visits to

practices and case study, with links between the use of skills and key performance indicators being identified.

Sometimes, stated aims in the definitions of successful consultations found in the interactive seminars were not demonstrated in the observations of consultations. An example of this was 'booking a recheck'. In one practice 'W', this was part of the definition of success, but in a whole afternoon of observations of consultations, the booking of a recheck was never once observed. This could have been because the recheck was flagged up on the computer typed in by the vet for the receptionist to pick up, but even then there was still no explanation given by the vet for a recheck in the observations. Part of the reason for this appeared to be linked to the vets' definition of success as not including recommending any procedure, but rather leaving the options open for the client to decide rather than the vet 'telling the client that a recheck was necessary.'

The strong appreciation of time management by the vets in this research was a strong motivator for vets to learn consultation skills.

Previous experience using didactic teaching in the practice had proved of very little or no value in helping a different group of veterinary surgeons to improve their consultations through changing their behaviours. Some of this group of veterinary surgeons had had a limited amount of training at their Veterinary Schools, and subsequently at meetings organised for them at about 1 year post graduation. The significance of the importance of the consultation skills seemed to be much more appreciated from the Group approach, as judged from discussions with the vets, and also the analysis of the change in performance with respect to ATV's and numbers of clients seen.

It was not satisfactory to analyse or assess consultations without an element of reflection from the veterinary surgeon doing the consultation. This was found in the literature review (Adams, 2006), and in applying the research instruments in the field work in the training group and the visits to practices.

During the period of the training and development meetings March 2005 to December 2005, there was a substantial rise in the numbers of 'tiny consult fees'. This illustrated that the individual perceptions of the veterinary surgeons were powerful influences on their consultations. It required a powerfully visual presentation to effect a change in their behaviours.

However, the definition of what these figures contained was 'the percentage of dogs or cats on prescription diets expressed as a percentage of the total number of dogs or cats.' This could have some different interpretations because it was not an analysis of the processes involved in the consultation, or the recommendation of the diet by the vet. It was an indicator of the supply of the initial diet in a bag or tins. The subsequent follow up to see whether or not the diet was continued to be purchased for the condition being treated and managed for the longer term was not analysed in this data.

Discussions with the computer programmers who organised and retrieved this data showed that this data could be further analysed into the percentage of animals who's owners bought the prescription diets for more than 6 months in a calendar year, but this would not be truly representative as an answer to the question of compliance because there would be dogs and cats who started on the diet in November or December of the year and so the data retrieved for these pets would only record purchases for 1-2 months, even if they went on to buy the diet for the following 6 months. This data collection could have been improved by using a longer period of reference if the data was available on the practice management system.

An interpretation of this analysis could have been that there were stages in the cycle of learning in the Group. Firstly, the new subject matter and issues were raised and discussed. Initially, this was generic (February 2005), and then became more specific about 'effective recommendations with examples and illustrations from the AAHA survey (April 2005). When the subject was revisited in November 2005, and a

decision to introduce an incentive scheme for clients for purchasing prescription diets appropriate for their pets' needs, this embedded the learning and achieved the implementation stage of the learning cycle. The next stage was to obtain reflections from the Group about their experiences after presenting the results to them at a meeting in May 2006. This may have lead to a change in the nature of the meetings from a focus group to a learning set. The development of the meetings was ongoing beyond the time frame of this research project.

A limitation of the audiotape analysis was the inability to analyse whether or not the veterinary surgeon was charging properly for the professional time, and also the services delivered as a result of the consultation. The observations did not include the inputting of data on the computer in the consulting room, except to note that some veterinary surgeons deliberately took time after the consultation to write up the notes, whereas most veterinary surgeons wrote up the notes while they were conducting the consultation.

## **Chapter 6. CONCLUSIONS.**

A substantial body of evidence has been gathered from the literature and qualitative research in exploring links between consultation skills and key performance indicators. There were considerable opportunities to use the extensive medical literature and apply it to the veterinary consultation, about which there is a very much smaller volume of literature.

A variety of methods of exploring the processes and outcomes were identified and researched. There were variations in the use of the various methods in how they could be applied to analysing the close interactions between the veterinary surgeon and the client in the consulting room, and there were variations in the sensitivity of the veterinary surgeons to having their consultations analysed.

An important part of the approach to this research project was that the consultations were observed with no intent to compare them overtly with any other veterinary surgeon or standard. The veterinary surgeons themselves were asked to give their own definition of success, which meant they were consulting within their own chosen performance criteria and no criteria were imposed on them.

There were variations in the use of consultation skills used by veterinary surgeons in this study, and also their approach to the consultation and analysis or performance. There were a significant number of agreements in the discussions and seminars with veterinary surgeons in what a successful consultation looked like, and also what the processes were and hence the competencies involved. Performance evaluation in consultations was related to the vets' actual definitions of successful consultation. Obtaining the vets' definitions of successful consultation was easy, and therefore a good way of predicting actual performance and the needs for training and development.



Variations in individual vets' performance were found to be very significant. Identifying the processes involved in the links between consultation skills and KPI's was found to be usefully explored using a variety of methods of analysis.

Performance assessment could be used to evaluate the use of competencies, but evaluation of competencies (can do) to predict performance (actually does) was found to be complex and could only be explored to a limited extent within this project time frame.

The purposes for which the exploration of analysis could be used included:

- Quality assurance and reliability of performance in consultations for the practice
- Quality assurance and reliability of performance in consultations for the clients and patients
- Quality assurance and audit for continuing professional development and self directed learning for the vets

Some authors have suggested that a clear understanding of the purpose for which an analysis is being carried out is vitally important. The evidence from this research shows that this is important, but the issues involved are complex, and it was possible to use either a variety or the same analytical method for different purposes. The complexity of the issues needed triangulation of the evidence to achieve reliability, but there was a richness in the qualitative approach to analysing consultation skills which enabled the achievement of validity, reliability and applicability.

The evidence suggests that in order to achieve an understanding between the consultation skills and performance, a practice and the veterinary surgeons working in the consultations need to have in place the following:

1. Training and Development Group on consultation skills and a demonstrable audit trail of meetings with minutes and outcomes and reflections.
2. Evidence of attempts to analyse some consultations, either through audiotapes, observations, and/or post consultation interviews.
3. Evidence in the form of results of analysis of consultations for individual veterinary surgeons in the team.
4. Performance appraisal, which has reference to consultations.

The purpose of a consultation could be derived from the vets' definitions of success researched in the seminars and visits to practices. Success could be rephrased as 'was the purpose achieved?' This was critically important because the criteria that the clinician personally uses for reflecting on and judging their own success or purpose impacts directly on the processes in the consultation and the outcomes.

Consultation skills, definition of success in consultations, and key performance indicators have been redefined from this research. KPI's that have been traditionally used in veterinary practice do not necessarily contain many of the vets' own definitions of success, and they do not measure the processes involved in the consultations. However, the new performance indicators and an imaginative use of qualitative analysis did help to find meaningful links to consultation skills, and a better understanding of the relationships between consultation skills and traditional KPI's. Improvement in both the new and traditional KPI's (eg: ATV's and numbers of transactions) was found by the use of a Training and Development Group. There was a variation between the individual veterinary surgeons in response to the development opportunities in the group. Some veterinary surgeons responded better than others, and overall it was judged to have been a useful activity, which produced improvements in financial and clinical parameters.

The findings from the case study/training group tended to confirm the hypothesis that doing more work does not necessarily create more income, and the quality of work can be difficult to maintain at higher volumes. The more efficient sharing of work

volume between the veterinary surgeons in the team, building their consultation and other skills can significantly add to both the overall quantity and quality of work done, with a commensurate increase in gross turnover, and profit. A consequence of this is that the practice can grow and there is less of a tendency for any one member of the team to become unequally, unfairly and unhealthily overburdened with fatigue.

The following table draws together the findings of this research. The main conclusions about what links have been found between consultation skills and key performance indicators are summarised in this table.

<b>Vet behaviour</b>	<b>Consult skill</b>	<b>KPI</b>	<b>Best link</b>	<b>Evidence base</b>
Incorrect charging for consult	Perception of value and worth of consult	ATV, Gross Tnvr, Nos of 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> & other consultations	Numbers of 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> and other consultations	Training Group Meeting March 2006.
Elicit client concerns; patient/client-centredness (Stewart, 1984)	Listening proactively, good use of open and closed questions	Numbers of services delivered; e.g. diagnostic and vaccination ratios (Moreau); time to vet interrupting client/balance of remarks in consultation between vet and client.	Focus on various products and services delivered measured in numbers	RIAS (numbers of client questions, numbers of supportive remarks by the vet/back channel responses); sales of product categories (eg: nutritional); post consultation interviews and questionnaires.
Good/bad adherence to appointment times	Time management	Numbers of appointments which are on time/late; effective use of nurses and referrals to nurses	Good balanced use of questions and remarks in the time slot allocated.	RIAS; client feedback questionnaires and interviews.
Interest in long term case management	Good explanations of diagnosis, prognosis and treatment; use of case management aids/tools eg: diagrams, health assessment record/charts	Numbers of repeat visits to the surgery; audit of compliance with practice protocols (eg: numbers of heart cases having ECG every 6 months)	Numbers of 2 <sup>nd</sup> and 3 <sup>rd</sup> consultations compared to 1 <sup>st</sup> ;	Numbers of rechecks booked following 1 <sup>st</sup> consultations; observations and interviews; audiotapes and RIAS.
Appropriate greeting	Ability to choose appropriate greeting for the client and circumstances	Consistent greeting recorded in audiotape	RIAS showing balanced use of remarks and not excess chat to exchange of medical information ratio	Observations, audiotape, RIAS.
Appropriate body language	Use of handshake, eye contact	Observations of these, either directly or by videotape	Observations and interviews	Observations or videotape.
Inquiry for working diagnosis	Listening proactively, use of open and closed questions			
Making recommendations	Ability to explain and answer client questions	Analysis of individual vet performance figures for numbers and value (£) of products and services	Performance figures linked to RIAS and observations, interviews and client questionnaires	Performance figures (numbers and £)
Inability to change	Improve	Static personal ATV and personal gross turnover (£)	Reflection; willingness to participate in a choice of analytical methods	Training Group Meetings

Where the analysis of the process was detailed and well thought through, the selection of the KPI most likely to be of value was more useful, and the link between the consultation skill and the KPI was stronger.

It was clear that attention to the processes in developing consultation skills in their own right, could add significant value to the service and performance of the veterinary surgeon and the practice.

RIAS was able to identify consultation skills being used, confirm or deny the veterinary surgeons were actually practising their own definitions of 'successful consultation' derived from the 1 hour seminar/workshops in each practice, provide a method of analysing consultation skills against some different models, help to illustrate the skills to GP vets, and provide a way of encouraging the development of these skills. Some links were found between the analysis of audiotapes, observations and interviews, and KPI's.

**What are the important consultation skills that the veterinary surgeons think should be measured but either are not or cannot be measured?**

This was one of the most difficult questions to answer in this research.

The veterinary surgeons commented in discussions in the practice visits and in the Training Group that soft skills were important but difficult to measure. Some commented that the soft skills simply ‘came with experience’ and were not appreciated. There was a variation in the perceived usefulness of the traditionally used KPI’s and financial indicators. The short answer appeared to be ‘if the veterinary surgeons can imaginatively define any skill, a method of analysing its use could be designed using some or all of the tools researched in this project.’

Some behaviours proved to be extremely difficult to influence or change. Three key examples were:

- Fee charging. Specifically where veterinary surgeons felt they should not charge the standard fees because they did not personally feel they could justify them
- Inability to share control of the consultation with the client, or accept they had an opinion, to allow them space to share their concerns without interruption
- Inability to strongly recommend a diagnostic procedure or treatment when a client asked the price

There were others, but the overriding principle was that a clinician’s inability to respond and change behaviours to meet the requirements of a successful consultation can have a very serious effect on client and patient care, business performance, and also the personal and career development of the veterinary clinician.

A higher assessed value of consultation can result in a greater volume and quality of veterinary healthcare delivery.

The time spent on education and training of veterinary surgeons in consultation skills can be linked to real and meaningful outcomes in practice.

The spirit of understanding was the central underlying theme of this research into consultation skills. This happened to be the title of the first sermon preached by the researcher following experiences at the World Boy Scout Jamboree in 1971, at which people gathered together from over 100 different countries and many different cultures and backgrounds. The journey has been a fascinating one. The potential impact of achieving greater understanding could be huge. However, no impact will be achieved if the veterinary surgeons in general practice do not see the wisdom of Stott and Davis (1979) who believed that there was exceptional potential in every primary care consultation, and the key to unlocking this was in seeing the consultation as a great opportunity.

The vets' own definitions of successful consultations (obtained from the interactive seminars in individual practices) were useful in explaining, critiquing, and analysing the consultations. Some of the vet practices chose different priorities, and included different components of care in their consultations ; eg : presence or absence of greeting. This was reflected in the presence or absence of these skills in the consultations. Therefore this analysis was linked to the use of consultation skills and performance, and it was linked to the ability of the vets to reflect and review their consultation behaviours with a view to changing for improvement.

## **IMPACT OF THIS RESEARCH.**

This research was done in ways that included and involved veterinary surgeons in general practice, the SPVS (See Appendix 'The political process') and RCVS. This enabled the research to develop solutions to meet real needs, and the potential impact was therefore significant.

The impact of this research was in some key areas for development of veterinary practice and the veterinary profession, and some useful points could add value to the already substantial work on consultation skills in the medical profession. A specific point was that client involvement in the assessment of the communication received needs to be included.

Methods of presenting the subject to seminars for veterinary surgeons were explored and some examples made available through this thesis.

Methods of presenting and discussing consultation skills in veterinary practice were explored with examples given of the use of Training Groups and Seminars in practice. This had a very significant impact on the delivery of clinical and financial performance in practice.

Methods of researching the processes within the consultation, and assessing consultation skills were explored and made available. This was very important for the educational development of the skills, and the development of the practice as a business delivering 'best practice.'

A new chapter in a new textbook ('Feline Medicine', Cannon (2006)) was published on the subject of 'Owner Communication' (Manning), which was the first of its kind on this subject to appear in a textbook.



Methods of measurement of key performance indicators (KPI's) were explored. A need was identified to widen the performance indicators commonly used in veterinary practice. Careful selection of the most appropriate KPI's on the basis of their quality was found to be very important for the research and development of consultations, which underpinned the management of successful delivery of veterinary healthcare. *Quality management should include qualitative analysis. (Appendix: Training Group, Conclusions of the SPVS Roadshow on Consultation Skills, Learning Diary Feb 22<sup>nd</sup> 2006).*

## **Summary of impact:**

### **1. Veterinary Practices**

All of these points have impact for veterinary practices in their constant endeavour to deliver better service in changing market conditions. A particular impact for individual veterinary practices is the potential for improving the management of change, especially the management of the changeover of veterinary surgeons when new veterinary surgeons are introduced to the practice and others leave.

The identification of consultation skills in individual veterinary surgeons as a separate entity from other clinical procedures is critical to developing the practice and the veterinary team within it. This is also essential in the recruitment processes in veterinary practices.

Tools have been identified that could encourage veterinary surgeons to take more responsibility for their own consultations and the impact they have on patients, clients and the practice.

The ability of veterinary surgeons to be able to respond to critique of their own consultations, whether that critique comes from clients, colleagues, the practice management or the RCVS or the VDS, is highly significant, and a major step forward.

The unique ability of the qualified veterinary practitioner includes the ability to make a diagnosis, which cannot be delegated. The reluctance of veterinary surgeons to charge appropriately for this professional service has an impact on the financial stability of practices, the appreciation by the clients of the value of this service, and the strength of recommendation made in the best interests of the patient.

### **2. RCVS**

The Royal College of Veterinary Surgeons has an interest in ‘maintaining public confidence in the veterinary profession’, and the two main areas of impact for the RCVS are the development of education in consultation skills and the opportunities to reduce the 80% of complaints from communication problems.

### **3. SPVS**

The Society of Practising Veterinary Surgeons (SPVS) has many opportunities from the use of this thesis for developing the continuing professional development for members in communication and business development. These are two areas of key importance to SPVS.

#### **4. Veterinary Nursing Profession**

Veterinary surgeons had some difficulties engaging the nurses in harnessing the potential for team performance in the delivery of professional health care. Evidence for this was found in the training group and the visits to practices.

A new Chapter published in a new textbook has placed the subject of communication with animal owners in the core subject matter for veterinary nurses for the first time in the history of this profession. The level of importance of consultation skills has thereby been given a higher profile in the training of veterinary nurses. This has been recognised in a review of the book by a Veterinary Nurse (Rudd, 2006).

There is more potential for the role of veterinary nurses in healthcare delivery in practice, but it does need to be carefully managed with improvements in the training and integration of nurses into the communications and consultations in practice.

#### **5. RCGP**

The importance of analysing the perception and understanding of the patient or client in the consultation needs to be addressed if a holistic assessment of the quality and effectiveness of the consultation skills is to achieve reliability. This has been addressed in the literature recently (Robinson *et al* 2002; McKinstry *et al* 2003), but is a complex area in which further research is likely to be helpful in both quality assurance and assessment of consultations.

There is a need to focus on the consultation. The ways in which KPI's are extracted from the practice management systems, interpreted and integrated into a holistic approach need careful and detailed consideration to produce reliable and consistent improvements to the delivery of service and performance. There is a need for computer software suppliers to the veterinary profession to develop and include analysis of individual veterinary surgeon performance, and the separate identification of the outputs from the consulting room and 'back of house procedures'.

KPI's can be linked to behaviours via consultation skills.

The power of the observation can detect a large number of random variables that are likely to be undetected in any other way. Similarly, a computer management software system can produce a very large quantity of data. The information that can be obtained from careful planning of observation, qualitative analysis, and the use of computer software can have high significance. Analysing 'chance observations' or data can have much more significance and impact if it is interpreted against a background where a good system is in place. A question that could be developed from this research is 'how does the clinician's performance change when some prescriptive processes are introduced to the consultation via a computerised practice management system?'

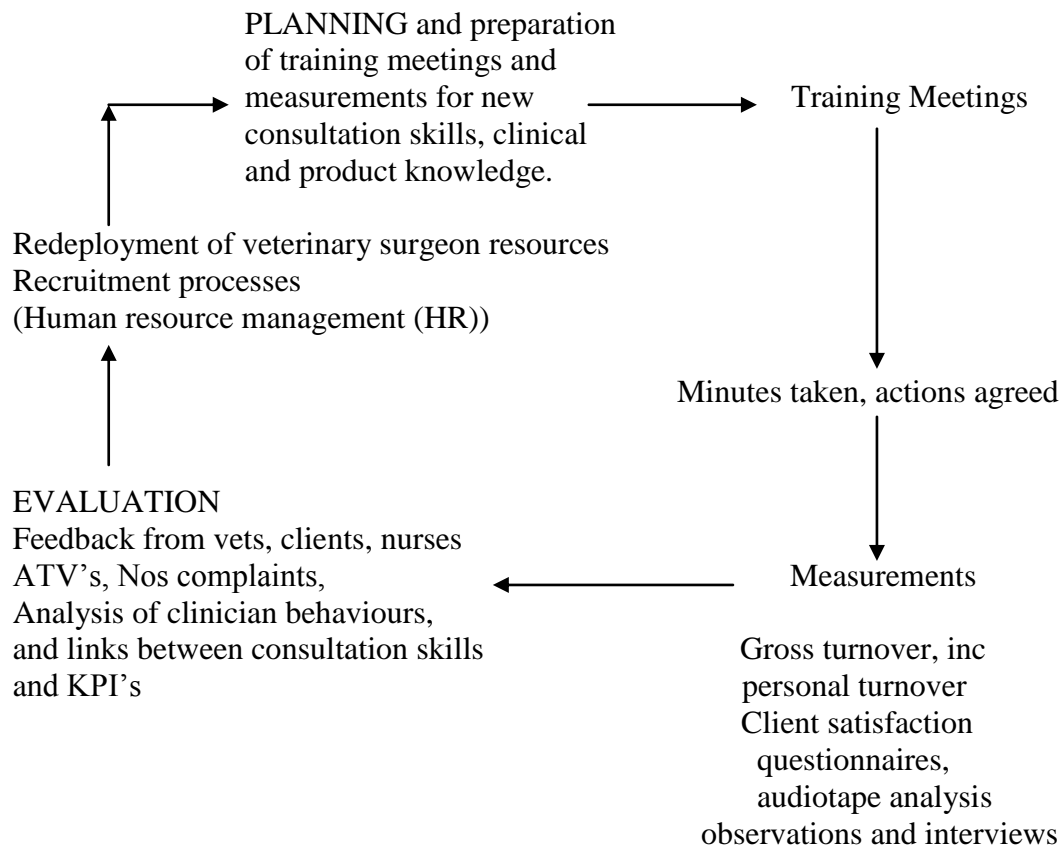
**6. Design of veterinary practice/clinical facility.**

The design and layout of the consulting rooms in a practice requires care and consideration of the requirements for consultations and how they work within the whole facility. This does have an impact on time management and efficiency, and therefore on the ability of the clinician to deliver best practice.

**7. Impact for the author-researcher-worker.**

The learning involved in this journey was very valuable in developing a better understanding of the processes in consultations, and how to analyse them. The outcome included better performance and a vision for the future in veterinary practice. The insights into understanding performance in the consulting room were invaluable.

### **The Learning and Management Cycle.**



**If anyone still thinks that consultation skills are easy, think again. Consultation skills are an essential clinical skill, which can be explored with academic rigour.**

**This challenges clinicians to include consultation skills in their core professional development, without which they cannot deliver the best of care for their patients and clients.**

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SPVS.

VPMA.

NAVC.

## **APPENDICES.**

### **Executive summary of the appendices.**

The published work of particular significance by the author has been about the use of observations and semi structured interviews to analyse consultations (Veterinary Review article); ‘owner communication’ in a chapter in a textbook for veterinary nurses which describes how a consultation might be done; and the SPVS Roadshow in consultation skills January 12<sup>th</sup> 2006 which brought a large amount of the research together.

Raw data collected from the Learning Set in my own practice is presented in ‘notes from the flip charts’ used, and similar data collection is presented here from the seminars conducted at the Veterinary Christian Fellowship annual conference and in the visits to practices.

Analysis of the consultations using the Roter Interaction Analysis System is presented.

A summary of the different models of a consultation from Dr Mei Ling Denney is presented, along with some reflections and other information from the SPVS Roadshow.

This provided the raw data for analysis and triangulation of the research evidence to produce answers to the research questions presented in an extract from the D4541.

## Appendix 1 :Article for Veterinary Review

SPVS Masters Group

**CONSULTATION TECHNIQUE** : adding REAL value IN PRACTICE : the semi structured interview.

Carol Gray ably described some of the work being done, together with some of its implications for the veterinary undergraduate curriculum in a series of articles in Veterinary Review recently (See References). Ann Holden also described some aspects of the consultation recently. The SPVS Masters research project that I completed and graduated MSc(VetGP) in Feb 2004 took me into different general practices from Kent to North Wales, and I found the research tool that I was using to be immensely valuable.

The feedback from over 900 veterinary surgeons in the BIG Questionnaire circulated by the SPVS Masters found that all but one of the 903 respondents thought that consulting skills were important or very important for the GP vet. In positioning the importance of communication skills and clinical skills, the veterinary surgeons scored clinical skills as the most important value in their service delivery with communication skills second. A smaller survey of clients showed that the clients placed 'ability to communicate and care' as their top priority for what they perceived as value from their veterinary consultation, and they placed clinical ability and skill second. This reverse perception can have large implications for the GP consultation.

One of the joys of communication between human beings is that it is so delightful. Maybe you have a different view, which varies depending on the time of day. Maybe you remember choosing to be a veterinary surgeon because you thought Doctors had to do all the 'understanding and talking to patients' and as a veterinary surgeon you wouldn't have to...at least quite as intensely at any rate.

Well, it is hard work communicating under pressure, but it is important for delivery of service and financial performance. The good news is that it can be very interesting in general veterinary practice, and IT'S A WHOLE LOT EASIER IF YOU REALLY ENJOY IT.

Do you think about how you do your consultations, how you said this or that, what you did not say, how well your clients comply with your advice? How about using a tool that can give you the answers to these questions? I looked at the SEMI STRUCTURED INTERVIEW in my SPVS Masters Research Degree.

How I did it.

I was very grateful to the volunteer veterinary surgeons who allowed me to visit them in their general practices to continue my research. Good preparation and discussion beforehand were very important to ensure that everyone was comfortable with what I was proposing to do, and most veterinary surgeons agreed to participate. Some were nervous and respectfully declined. The preparation took account of the varying approaches and feelings, attitudes and understandings of having an 'outsider' come into the practice and make some observations in what is often felt to be 'the inner sanctum' of the practice where some defensiveness and sensitivity is felt by the vets. Whilst previous authors have described what happens from a

safe distance, my aim was to break the ice and to find ways of researching what really happens in the interaction between the veterinary surgeon and the client and patient.

The aim of the semi structured interviews was to observe the consultations and then interview the client and the veterinary surgeon separately afterwards, asking the same relatively simple questions, to see if there was agreement or any areas where misunderstanding had occurred.

Some results and observations.

Over the years, I have found that stress causes a loss of communication power. Stress associated with problems of time management is likely to push the veterinary surgeon into asking more closed than open questions, which reduces the opportunities for eliciting clients' concerns; which in turn produces less in both what the client perceives as service, AND what the veterinary surgeon actually delivers. A good example of this is the process of finding out about owners' perceptions of pain. I suspect that in many practices the vets' perception of the clients' perception of pain is less than it actually is because I found in my research that the clients positively effervesced with CARING about their pets, whereas the veterinary surgeons had a great deal more difficulty answering the question 'How well do you think you cared for the pet and the client?'

Overall, the veterinary surgeons I visited were scored very highly indeed judging from the appreciative comments and feedback from their clients, and the clients really enjoyed participating in 'a project that the practice had engaged in to continue to try to improve the service being provided to clients and patients.'

Some lessons were learned that illustrate some of the benefits of obtaining this kind of feedback. One client felt that the main problem with her cat was that 'it was the eye problem, definitely the eye problem.' I asked the couple in their 60's if there was any other important advice the veterinary surgeon gave them. After discussing this, the couple said 'No.' When I asked the veterinary surgeon what the problem was, she said 'it was definitely the weight problem. The cat had been obese for 3 years in spite of her efforts to reduce the weight, and the owners had bought the low calorie diet, but after weighing the cat no achievement was found.' (There was no eye problem found after examination with the ophthalmoscope).

Another case in an 8 year old Labrador was a routine booster vaccination, but the lady owner reported that the dog 'was a bit stiff in the mornings.' After the veterinary surgeon had exhausted questioning the owner and discussing the details of the problem, 'how stiff was stiff exactly?' a short course of antiinflammatories was prescribed and the owner requested to ring back in a fortnight to discuss progress. When I interviewed the client afterwards in a relaxed environment, I simply asked the question 'was there any other point you would have liked to discuss that wasn't covered in the detailed consultation with your vet?' The lady responded 'well, I would have really liked an x-ray of the hips because in the last practice we went to before we moved house the veterinary surgeon there had x-rayed the hips and found severe hip dysplasia and was told the dog may not be able to walk beyond 10 years of age. We were naturally very worried about this.'

In both of the above examples, there was potential for eliciting more concerns, and producing arguably better outcomes. In the first example with the obese cat, the veterinary surgeon had concerns but she felt she would not push the sales of the low calories diet unless there was a clinically detectable problem such as a heart or liver or diabetes problem. In the second

example with the Labrador, the owner had more concerns than the very caring veterinary surgeon was able to elicit, and so the client had some unanswered questions, whilst the veterinary surgeon arguably missed out on a potential opportunity for more detailed diagnosis and prognosis.

It could be argued that there were mitigating circumstances which influenced these outcomes, or that the practice systems had other ways of communicating these points with the owners. However, my point is that in reality there is no stronger or more powerful opportunity to influence the clinical outcome than in that face to face interaction between the client and the veterinary surgeon who they trust and like so much....Yes they do love you! My research found that the clients mostly scored the 'care that their veterinary surgeons provided for them and their pets between 4 and 5 out of a possible maximum 5.

An interesting point is that often clinicians (Doctors and Vets) are more concerned with the here and now than the future and the prognosis or prevention of further disease or illness. My research showed that prognosis was given a lower priority than naming the condition or explaining the treatment. Clients' unasked and unanswered questions might include : how long will it take for the diarrhoea to clear up Doc? or what's the point of these heart tablets? It's worth asking yourself what information you have given and expect to be complied with and understood and why after a consultation because the clients value the prognosis more than the diagnosis in many cases.

Another simple but very effective tool to encourage better follow up by the veterinary surgeons and their support team, AND improve client compliance AND client bonding is for the veterinary surgeon to print a label at the end of a consultation recommending a telephone call is made after 1,2,3 or whatever months to check on 'how's he doing Mrs Jones? I just thought I would give you a call.' The labels can easily be stuck into a 'nurse referral by veterinary surgeon book in a monthly diary format' for example.

Combining nurse and veterinary surgeon consultations can be a very effective way of developing these activities provided the communication pathways are well understood. It is often a good idea to utilise a nurse to talk on the client's level after a complex or distressing consultation for example, but don't forget as well the large amount of potential added value from what you might regard as a 'simple vaccination,' but is in fact a huge healthcare opportunity.

The potential for increasing your clinical service delivery, financial performance, owner compliance and satisfaction is enormous. The biggest cause of stress to GP Doctors is 'unfinished business' which means all those jobs that did not quite get done that they are still trying to juggle around in their heads during and after the end of the day. I suspect the same is true of veterinary surgeons who tend to be perfectionists 'I wish I could have done that better...if only I had time....I wonder if the owner will really carry out my recommendations.....'.. So what's stopping you getting started into working on your consultation skills? Remember you don't have to be a new graduate to need to learn more : the two veterinary surgeons who produced the examples above had 35 years combined experience between them.

If you would like to develop or enhance your skills more, or find ways of encouraging and developing these skills in your veterinary colleagues, you can do this and support the research in this important area of veterinary practice through initiatives in the SPVS Masters Group. Consultation skills will be a part of the new RCVS modular Certificate in Advanced

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Veterinary Practice (CertAVP) hopefully being launched in 2005. I am continuing to develop ideas through my Doctorate research in conjunction with Middlesex University and the Professional Development Foundation. If you would like to participate and be included in my next series of visits to practices (no cost to you, only a bit of your time), in the first instance please contact me at:

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## **Appendix 2 : Article for Vet Business Briefing**

### **VIEWPOINT ON FACTORS INFLUENCING OWNER COMPLIANCE**

The outcome of the consultation in a Veterinary School or probably also a referral centre are likely to be in line with what the veterinary surgeon feels is 'expected from best practice.' However, in general practice, there are many factors affecting the delivery of 'best practice' which require skills that are not really taught to undergraduates or developed in postgraduates to a level that seriously addresses these challenges.

A good example of one of these factors is the vet's perception of cost and value. In the veterinary school or referral centre these are not so real as in general practice where they are entangled with all sorts of emotive, ethical, and business issues that are poorly understood or worked through in a logical way. This 'baggage' gets in the way of service delivery, although if well analysed can provide the springboard to service delivery and owner compliance. In simple terms, the phrase 'don't x ray the client's wallet' is the instruction to the veterinary surgeons in a general practice, but unless the reasons are understood it still happens.

Effective communication of why a treatment is being recommended, or why a diagnostic procedure is needed in 'the best interests of the animal' is vital in delivery of the best practice desired by most vets. Reinforcing this message by utilising illustrations, bone models, further explanations and support from nursing staff and follow up appointments is very important.

An organised and integrated support system for the consultations is very likely to have a huge impact on service delivery and owner compliance; and this is likely to optimise and grow practice clinical and financial performance. Measurements of the key performance indicators (KPI's) help to maintain high performance in service delivery and owner compliance. Many practice management systems are able to measure performance figures in overall terms such as numbers of sales of wormers, numbers of consultations, average transaction values and gross personal turnover. However, a more subtle system that aims to measure the performance of the veterinary surgeon in the close personal interaction with the client in the consulting room can yield large benefits both in creating better performance and compliance, but also in developing the soft skills that the veterinary surgeon needs to deliver these

important aspects of service. It is important to utilise selective and appropriate performance measurements to encourage the veterinary surgeons to improve their performance, and links to clinical excellence and its delivery are strong motivators compared to the often less well appreciated or understood financial measurements.

Key areas of training for veterinary surgeons to concentrate on with the maximum return for effort include:

1. Perception of value of practice products and services.
2. Proactivity in promoting practice services and products.
3. The vet-client interface in the consulting room.

The fact that measuring the soft skills has not been easy does not mean that it should not be done, or that success cannot be found by trying to do this. I have been developing techniques in my own practice, and have found that my visits to different practices conducting interviews of veterinary surgeons and clients after consultations was very interesting and useful. I am continuing this work through 2004/2005, and am looking for more practices to participate. I have been trying different types of questionnaire and semi structured interviews, which I intend to bring with me as I visit practices. If you are in the USA, and would like to participate, although I cannot visit you easily in person, I could send you some structured questions to try in your practices, from which I would appreciate your sending me the results in the form of the answers you get from the veterinary surgeons and clients. This will help me to gather a pool of data to analyse. There would be a slight disadvantage in that I would not personally be able to discuss with you how to do the interviews and the detailed questions you may have about why you should be doing this to improve your practice performance and service to your clients and patients, but you could email me your questions for a response over the ether.

I did find that some lively discussions occurred in some of the practices that I visited, and that can only be a good thing. Participants do benefit from thinking about how they and their colleagues consult with clients, and added value and higher percentage compliance can be achieved through the greater understanding of what is happening in these beautifully created human interactions.

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### **Appendix 3 :Raw data from Training and Development Group.**

Group Meeting No 1 : Tuesday 8<sup>th</sup> February 2005 (Veterinary surgeon A was the worker researcher)

Attended by : A, B, C, E, F.

Apologies from : D.

I used the newly purchased PowerPoint projector to display the presentation slides and stimulate interactive discussion.

#### **Consultation skills for Astonlee Vets**

High importance : national survey showed all but 1 of nearly 1000 respondents either agreed or strongly agreed with the statement 'consultation skills are important for the GP vet'

Similar numbers thought these skills were important to the delivery of service

Ideas?

#### **What is a successful consultation?**

A's: Correct diagnosis and treatment, satisfy the client, client understands and agrees, meet the client expectations, owner is convinced, animal happy, veterinary surgeon is happy.

A commented: I would like to add 'profit from the time' as part of the definition of success. Also I have found that veterinary surgeons have left the practice or felt intimidated and upset over the issue of not being able to do what they wanted for the animal, and C confirmed this was important.

A's definition of a successful consultation

The definition I have constructed is 'the effective sharing and imparting of medical information relevant to the patient, and addressing the concerns of the owner.'

*I will know when I have been successful in my Doctorate research when I have accumulated data and analysed it in ways, which convincingly demonstrate linkages between the implementation of consultation technique and clinical outcomes.*

#### **Ideas?**

#### **What are successful outcomes of a consultation?**

A's:

Success is indicated by :

The client brings the animal back for a follow up

The desired or anticipated outcome is achieved

The owner thanked the veterinary surgeon and was appreciative

The client asked to see the veterinary surgeon the next time they came to the practice

Choices were offered to the client

'If the owner is happy, the veterinary surgeon is happy, even if the outcome was not what the veterinary surgeon wanted.' A commented that this was really revealing because the oath sworn by every veterinary surgeon on admission to the RCVS is 'it shall be my constant endeavour to ensure the welfare of animals under my care.' There is no mention of clients in this oath. F commented that the care of clients was covered by the code of professional conduct.

Failure is indicated by :

Moaning client

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The outcome was not the desired or anticipated outcome

The client asks to see someone else the next time they come to the practice

The client misunderstood what was said

The veterinary surgeon 'knows the client is not going to comply, especially if they agree too quickly or say 'I'll ring back''

### Ideas?

### What skills do you use to achieve your success?

Examples were used of recent cases seen by the vets.

C had a hyperthyroid cat that was not responding to medical treatment, and so the issue facing the veterinary surgeon and client of the risk of general anaesthetic and surgery forced the issue. The outcome was a successful recovery for the cat.

E had a greyhound with a tumour/osteosarcoma of the distal tibia in a hind leg. E offered amputation of the leg and chemotherapy, taking time to fully explain all the options, demonstrating the xrays, trying not to push the client into a decision. E then gave the client time to think about the options at home and discuss between husband and wife before coming to a decision. The outcome was that the client decided to go ahead with the recommendations, and the dog is doing well with the treatment.

Taking time

Talking

Encouraging

Giving examples of previous cases

'Promoting services to meet client needs was acceptable as long as it did not sound like the dreaded 'selling.'

Ideas?

What measures do you use to demonstrate your success?

C expressed her feeling that she felt anger with clients and had to bite her tongue sometimes when they said they 'could not afford the treatment.' C found this especially when the client gave a 'point blank refusal.'

Key performance indicators

Vet	ATV	Nos clients	Gross turnover	(Dec 2004)
A	£69	292	£20,042	
B	51	91	4,640	
F	42	280	11,627	
D	47	261	12,150	
E	35	142	4,908	
C	49	218	10,655	

Totals	50	1284	64022	
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Nurses' performance does add real value.

A introduced these as examples of some measurements he uses to manage the practice. C was strongly of the opinion that too many measurements were not motivating the staff, but that 'looking after the staff was motivational or demotivational if staff felt uncared for.'

Nurse contribution : business plan

How could you improve?

Ideas?

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A commented the nurses played an important role, so we should use them widely.

### **December 2004**

Transaction volume : Dogs = 1259; cats = 822.

New dogs/puppies : 121

New cats/kittens : 105.

Due for vaccination : dogs 443; not revaccinated 328.

Cats 336; not revaccinated 206.

Vacc patients 1-2 yr : Dog 23; cat 20.

Dentals : Dogs 7; cats 15.

Client transactions 2600 approx.

New clients 42. Leavers 5.

Hospital nights : 175 (has been up to 230 in August and November).

Nurse clinics : 120 (has been 170 in Sept).

OOHR's call outs : 17.

Booster reminders sent : 450.

Cat vaccinations : 200 (rising trend).

Dog vaccinations : 195 (rising trend).

A gave these examples of more measurements used in managing the practice. The general comment from the veterinary surgeons was 'this was not what they were really interested in'. There may be more feedback on this point after the meeting.

Protocols.

Protocols suggested by E.

Discussion and action plan.

E gave out 4 written protocols which she had prepared, for all of the vets. It was agreed that the veterinary surgeons would all read these, and pass comments back to E within 14 days before she considered all comments and then typed them up and distributed them around the practice. It will be interesting to see a) how all the veterinary surgeons come to an agreement on what is 'best practice' through each of these protocols, and b) what effect it has on implementing best practice' and how the frequency of implementing these protocols helps to improve the delivery of our service.

### **KEY POINTS EMERGING FROM THE MEETING SEEMED TO BE:**

Veterinary surgeons focus on the client rather than the animal because they feel intimidated, and VDS/SPVS Competition Commission all focus on 'litigation is terrible!!!' Veterinary surgeons need to get involved and not be held back from providing care for the patients.

Money/numbers is a turn off, but needs pursuing. There are numbers on the pay cheques!

Flavour of numbers was given to show a starting point for comparison later in the year.

veterinary surgeons resisted selling very strongly, but missed points about offering best medicine by miles. B was less anti-selling because she could see 'best medicine needed promoting.'

No mention of profit or money in the definition of a successful consultation, except by A!

This powerpoint presentation would be good as an introduction to visits to other practices as planned in A's Doctorate, possibly as a handout/worksheet.

Gastric Dilatation/Volvulus (GDV) was discussed. C asked what she should do if A is away and a case turns up as an emergency, in which to refer would not be an option because travelling time could result in the death of the dog. A responded 'do it'. A good discussion took place to air C's concerns and solutions were offered by A and B as to how to deal with it, using the recent example in which A assisted E by attending and carrying out the surgery on a Boxer which was successful.

Use of prevaccination forms was rather denigrated by the vets.

Ward round/case conferencing. We have just started night duty nursing with a nurse on premises quite a high percentage of the nights which should ease the burden felt by the vets, and facilitate the night work done by the veterinary surgeons and the practice, improving care of in patients at night. There is

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a handover 7.50pm from day staff to night nurse and night duty vet. Night nurse hands over to day nurse 7.50am. Veterinary surgeons case conference around 2-2.30pm was agreed as a good time to try to get together for discussions. Some protocols are needed to be developed for what procedures can be done by the night duty nurse and what by the duty vet; eg: IV diazepam. There needs to be a fee on the computer for each of these procedures which need to be charged as individual items. This is very important to develop.

Topics to develop for next month : numbers of 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 5.30pm consults for each vet, other numbers of prega blood tests, phenobarbitone assays, ultrasounds related to implementation of protocols.

Group Meeting No 2 : with the nurses at Astonlee.

Paul Manning leading.

Friday 18<sup>th</sup> February 2005.

Attended by whole nursing team (7 present with 2 apologies for absence), with Veterinary surgeons C, F listening in.

Consultation skills for Astonlee nurses.

High importance : national survey showed all but 1 of nearly 1000 respondents either agreed or strongly agreed with the statement 'consultation skills are important for the GP vet'

Similar numbers thought these skills were important to the delivery of service

Ideas?

What is a successful consultation?

Nurses unanimous in definition as 'satisfied client' which includes client understands, they are sold something or explained their needs.

Nurse job satisfaction also important.

Barriers to 'selling' : perception of money and cost, more than one thing at a time makes nurses feel they are selling rather than meeting a single need even though there are more than one need identified, TIME MANAGEMENT is very important, client may be interested another day.

Nurses could refer to a veterinary surgeon for further examination of 'dirty ears'. Put 'to vet' on computer.

Need to motivate clients, but nurses felt that 95% of clients actually did what they were asked to do or were offered, so that's a huge potential and opportunity to deliver service.

Stitch removals : nurses feel they always offer flea, worm, chipping and pet insurance. Felt that a poster would help for fleas, giving the 1<sup>st</sup> tablet helps with worming, leaflets help with pet insurance : all visual aids which clients like and aid communication. Remind of vaccination if overdue or coming soon.

Explaining why advice/benefits better to prevent fleas than wait until there is a problem.

'My own cat has this product' helps a lot.

Making a fuss of the animals is very important and useful; owner is there to care; show that you care.

A's definition of a successful consultation.

*The definition I have constructed is 'the effective sharing and imparting of medical information relevant to the patient, and addressing the concerns of the owner.'*

I will know when I have been successful in my Doctorate research when I have accumulated data and analysed it in ways, which convincingly demonstrate linkages between the implementation of consultation technique and clinical outcomes.

What are successful outcomes of a consultation?

Ideas?

Client got 'extras'

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What skills do you use to achieve your success?

Ideas?

Open, approachable, be quick to assess characters of people, good examination and observation skills.  
Don't shout at the client.  
Ask open questions about feeding and exercise.  
Have conversation, explain benefits.  
Encourage client towards benefits of healthcare.

What measures do you use that demonstrate your success?

Ideas?

Nurses felt that 100% of weight clinics return for their 1<sup>st</sup> checkup.  
Weigh everything that comes into the surgery is ideal but not achieved yet. Some clients weight their own pets, and this should be encouraged and reported to reception to record on computer.  
Clients like continuity. When Head Nurse left in October the numbers of weight clinics fell dramatically because clients like to see the same person. (THIS IS EXTREMELY IMPORTANT TO INVOLVE MORE NURSES IN THESE CONSULTATIONS TO AVOID A DROP IN NUMBERS BY SPREADING THE CLINICS AMONGST SEVERAL NURSES AND GROWING THEM ALL).

Numbers of veterinary surgeon referrals by nurses.

Key Performance Indicators.

Nurse ATV    Nos clients    Gross turnover    (Dec 2004)

Nurses performance does add real value.  
Astonlee plan offered  
Dental booked in  
What do think is the most important you do?

Answer from the nurses was : ' LOOK AFTER THE ANIMALS '. I then asked them why it was they had started off saying their definition of success was 'happy clients' when in fact they thought the most important thing for them to be doing was 'care for the animals'. They resisted this point, but a good discussion developed about why they felt the clients wanted something different from the nurses. (I personally believe this is not true).

Expression of CARE is so very important.

Promoting health is very important.

Offering Astonlee Plan and/or PetPlan is very important because it helps to ensure that clients are prepared to pay for the diagnostics and treatment of their animals, and do not place the practice in the position of being asked for 'charity which we do not have.' Nurses need to record on the computer when they have offered these Plans so that reference can be made back to this point either when receptionists are asking for money in payment and clients are refusing to pay, and also so that other staff can ask again 'have you considered the leaflets on the Plans given to you earlier?' This all helps the business to care for the animals.

Nurse contribution : business plan  
Business plan established by new Head Nurse.  
Example 'Service Performance Indicators' (SPI's)

## Paul R. Manning project report

Nos Hospital nights (ranges 60-230pm, rising)  
Nos nurse clinics 120-200, falling Nov, Dec  
Miscellaneous sales each nurse £40-200 pm

There is a big difference between what some nurses do in the consulting room, and the opportunities are there. However, if opportunities are not taken the difference can be as much as £40 to £200 per nurse, which times 10 is a lot of difference each month.

New Head Nurse has been working with A to produce a business plan for the year 2005, and needs to develop service performance indicators to measure and feedback to A as representative of the nurse team every month. Ideas from the nurses are needed on what should and can be measured that is easy and relevant. The current list under 'nurse' on the computer can be used and added to. The nurse team are to work together to produce some measurable objectives.

How could you improve?

Ideas?

Veterinary surgeons could assist in promoting the use of and appreciation of the nurses by using the names of the nurse called into the consulting room and introducing them to the clients. This is a small but easily accomplished point, which could make a big difference.

December 2004

Transaction volume : Dogs = 1259; cats = 822.

New dogs/puppies : 121

New cats/kittens : 105.

Due for vaccination : dogs 443; not revaccinated 328.

Cats 336; not revaccinated 206.

Vacc patients 1-2 yr : Dog 23; cat 20.

Dentals : Dogs 7; cats 15.

Client transactions 2600 approx.

New clients 42. Leavers 5.

Hospital nights : 175 (has been up to 230 in August and November).

Nurse clinics : 120 (has been 170 in Sept).

OOHR's call outs : 17.

Booster reminders sent : 450.

Cat vaccinations : 200 (rising trend).

Dog vaccinations : 195 (rising trend).

Protocols

Protocols suggested by Head Nurse and 2 other nurses.

Read A's chapter on 'owner communication'

Discussion and action plan.

Consultation skills (vets) March 18<sup>th</sup> 2005

A's reflections on this meeting:

This turned out to be a really important and potentially highly significant meeting because it identified a lack of enthusiasm and commitment in the veterinary surgeons to handling 'chronic cases' and it revealed a big hole in the practice in the veterinary surgeons who appeared to be less than ideally motivated for generating follow ups from their long term cases.

The potential for actual loss of business has been identified in reduction in sales of non steroidal antiinflammatories (NSAID's) over the past 4 months, which has been very significant in the practice management figures. Some of this is due to a distortion because of overstocking the drugs, but it does appear to be a real issue affecting sales and revenue, as well as number of visits by clients to the surgery.



## Paul R. Manning project report

Chronic cases and managing osteoarthritis

What is your definition of a successful consultation?

How do you decide to re see the patient?

How do you decide the interval and frequency of the rechecks?

How do you ensure your rechecks are implemented?

Discussions:

Veterinary surgeons defined success in their consultations with:

Owner understands the condition, animal is made comfortable, weight management is achieved, important to talk to the client about slowing down the arthritic process and potential for use of chondroprotective agents, exercise planning.

Deciding on frequency and time interval for follow up depends on the severity of the pain, but usually 7-14days initially and then every 3 months for rechecks.

Veterinary surgeons felt that clients were good at managing their pets' pain, and veterinary surgeons relied on this for the client to come for a recheck when the client felt it was necessary. Veterinary surgeons felt the clients preferred their own veterinary surgeon to phone them rather than an anonymous or unknown person from a drug company, but one veterinary surgeon felt strongly that the support from the drug company continuous support programme was useful and complementary to what she was doing for her patients and clients; and there had been good feedback on the scheme. A said how important it was for the veterinary surgeon to take responsibility for the care and decision making.

Pain assessment was considered to be highly subjective, but A encouraged the veterinary surgeons to think of ways to measure and record a pain assessment on the computer clinical notes for facilitation of the follow up appointments. BOEHRINGER (drug company rep and veterinary surgeon who came to the meeting and gave a presentation) said they had papers published including ways of measuring/recording pain, so we have requested copies for all of the vets. Assessments could include 'how stiff in the mornings/how many seconds does it take for the dog to get up and start moving around?' 'Is the exercise pattern normal? Or does he walk less far and for less time? Does he still jump into the car?'

Benefits of follow ups.

Why do you want to recheck your patients?

What benefits are there for the patient?

What benefits are there for the client?

What benefits are there for the vet?

What benefits are there for the practice?

What do you recommend?

Your patient does between rechecks?

Your client observes between rechecks?

Discussion.

The veterinary surgeons said most rechecks were 7-14 days after the first consultation, and the number of tablets or medication was designed to end just before the recheck appointment to help achieve owner compliance.

How do you recommend?

How do you ask the client to attend a recheck?

The Metacam continuous care scheme

What do you know about this?

How do you use it?

Why do you think this is a good idea?

Are there any obstacles to your using this scheme?

## Paul R. Manning project report

Justifying the recheck fee

How valuable is this recheck?

Why is it valuable?

How can you make the most of this consultation?

Discussion.

The veterinary surgeons said they had no difficulty in applying the practice normal fees for the rechecks, but A helped them to think about how they were able to give value for money in explaining the treatment, the condition and pain assessment.

Message about weight control was important, as was the ability to share concerns with the owner, and discuss potential side effects of the medication.

E said she encourages clients to keep a diary of walks, and to discuss this more at follow up consultations. If the client was very keen this was easy and desirable, but less motivated clients were not so attracted to this idea.

The veterinary surgeons felt that they achieved case continuity in the vast majority of their cases, and so they could judge pain comparing to their previous assessment.

The veterinary surgeons felt that a client questionnaire about pain was of limited value. A felt this could be explored and developed further, but clearly found that the benefits would have to be proven before the veterinary surgeons could be motivated to use this. This could be a very useful process to explore over the coming months.

Time Management.

Finishing appointment lists on time can be difficult ALL of the time, but learning to have confidence to pass cases to colleagues/staff on the later shifts is important.

There should be no compromise of standards of care by finish times.

Handovers and managing boundaries are very important : what are your issues with this?

Discussion.

The veterinary surgeons felt that time management was not critical to their consultations about arthritis, and they managed to finish in time.

Writing clinical notes and pricing.

Vital for clinical success

Vital for collecting payment

Vital for communication with colleagues and staff who are also involved in the case and/or communicating with the client.

The links between clinical excellence and income.

Are there areas in which you agree that links are achieved; if so what are they?

Are there areas in which you disagree that links are not achieved; if so what are they?

What paradigm shifts have you been challenged with during this seminar?

Service performance indicators

ATV

Ultrasounds

Vaccinations/preventive health care

Dentals and prophylaxis, nutrition

Parasite control/ecto/endo/children

Cardiovascular support

Musculoskeletal support ..over to Metacam

BOEHRINGER PRESENTATION.

Discussions with the veterinary surgeons and the veterinary surgeon from Boehringer.

## Paul R. Manning project report

Reasons why veterinary surgeons were not generally excited about long term case management....they tend to prefer to do what they call the exciting acute cases and traumatology, so the challenge is to find ways of making chronic care fascinating and rewarding.

Metacam is a safe product, kidneys and liver are very largely unaffected.

Metacam gives 24 hour pain relief compared to Rimadyl 12 hours.

Cheaper to use Metacam. (Veterinary surgeons said price was not an issue for them).

F has used Metacam injection but not otherwise. Boehringer think the volume of Metacam needing to be injected is smaller and less painful, but the veterinary surgeons do not find this a significant issue in their choice of drug.

Metacam has a high oral palatability.

F was at a loss to know what to do if an animal was not responding to pain relief, and did not think a change of NSAID would be worth a try....A and Boehringer encouraged F to try a change of NSAID, leaving just 1 day after the end of another medicine before changing.

E said that the metacam continuous care scheme was useful for committed and enthusiastic clients.....A and Boehringer said the scheme helps to support ALL clients especially the ones who are less committed, and C agreed with this.

A said that 'for clients, the relief of their pet's pain was a BIG concern.'

### ONE TO ONE DISCUSSION 3 DAYS LATER WITH F.

A discussed the use of some simple pain assessment criteria he tried in the morning consultations, including 'how many seconds did the dog take to get up and start walking normally in the mornings?' This helped to bring out the client concerns and deliver better care for those concerns through the use of additional chondroprotective agents. F acknowledged an understanding of this principle for improving consultation skills and the effective delivery of a successful outcome.

F asked how I was going to measure consultation skills. I replied that the first thing was to ask the veterinary surgeons to reflect on and write down their definition of a successful consultation, because without that it could not be measured. Then, there may be financial parameters such as ATV's which could be related to consulting skills, but for many veterinary surgeons behaviours (as the sociologists put it) may be the best measure of performance. For example if the fact that the veterinary surgeon smiles 55 times during a consultation is the behaviour that makes a successful consultation, that may be measurable, and if it can be linked to a financial parameter such as ATV that would be good. However, the measurement is likely to vary, but with some common denominators. This is what I am researching.

Consultation skills : making effective recommendations.

Attended by:

Vets

Nurses

Receptionists

Hills Rep Ashley Gray

YOUR definition of a successful consultation so far has included:

Keeping client happy,

Correct diagnosis and treatment, satisfy the client, client understands and agrees, meet the client expectations, owner is convinced, animal happy, veterinary surgeon is happy.

## Paul R. Manning project report

Paul says profit is important

F's definition was really that for him the veterinary surgeon is happy, and that means that he is doing everything scientifically. Chronic cases could be just as interesting as acute cases provided he has some background information.

Ensuring client understanding using open and closed questions was important.

Client is happy if they perceive they have received good treatment, reasonable pricing and general satisfaction of quality of service.

Veterinary surgeon might not do as well or be as happy if the environment was poor or there was excessive fatigue.

Facial expression of the client is important.

A pragmatic statement tends to work for C (she thinks). C also thinks she achieves a very high level of compliance with putting blocked cats onto a prescription diet afterwards.

Nurses think they achieve >90% uptake of slimming diets when clients come to the weight clinics. So the strong message to the veterinary surgeons and staff is to refer the overweight pets to the nurses.

C said she had a problem talking about overweight pets in front of overweight owners : discussed how to depersonalise the discussion and focus on the health benefits for the pet.

Veterinary surgeon referrals – printing labels for the nurse to phone client in 7days for weight discussions.

Weighing pets : try to do more 1) reception to ask clients to weigh their pets on their way into the vet; 2) veterinary surgeons and nurses to weigh more pets in their consults. 3) Veterinary surgeons can also ask clients to weigh their pets while they are writing up the notes to save time.

The handleless doors to the consulting rooms were thought to be an obstacle, but A pointed out the H&S reasons why they are there : 1) security 2) protection of children from access to hypodermic needles.

How do you know you have been successful?

Elicit client concerns by listening attentively, and asking open questions

Weigh the dog/check weight

Ask about what food they feed

Ask about why they feed that diet

Ask if they understand the dietary needs of the pet

The veterinary surgeons thought the vaccinations were less than 100% of recommendations. Clients coming for consultations about something else would be less compliant with a vets' recommendation for vaccination at that time or when the pet was recovered from the illness.

Need to ask about health and wellness at consultations and vaccinations, ask about what food the pet is fed at time of weighing.

Explaining the basics of diet does not take much time, most clients take up a recommended diet but do not stick to it, hence referrals to nurses can help potentially enormously here.

The first issues the client raises are not necessarily the real concerns. If palatability of the diet is a concern, need to ask open questions, owners can make treats with some of the KD diet for example.

Meeting the needs?

'We aim to promote the health and wellbeing of our patients for their own and their owners' enjoyment of a longer and happier life'

What are the needs?

## Paul R. Manning project report

Avoid obesity and related diabetes, liver disease, arthritis, heart disease.  
Avoid calcium and protein imbalances for the growing puppy and nursing mother.  
Avoid xs protein for the kidney patient.  
Avoid .....

Motivating the client.

Do they understand?  
How do you help them to understand?  
How do you explain the cost concerns to clients?  
What do you do to revisit client concerns during the consultation and the followup?  
How do you use the nurses for assistance?  
What do YOU believe?  
How strongly and enthusiastically do you recommend diets in the care of your patients on a scale (low)1-5(high) when they :  
Are puppies or kittens?  
Nursing mothers?  
Cat/dog kidney disease?  
Cat/dog liver disease?  
Cat/dog diabetes?  
Overweight cats and dogs?

C expressed difficulty in selling obesity diets to pets with overweight owners. Weighing is a powerful tool. Owners often feel they are feeding minimal already.

In Holland veterinary surgeons tell clients 'their pets are FAT'. The Dutch veterinary surgeons don't have a problem with this.

Pets are 4 times as likely to get diabetes if they are obese, and their owners are more horrified if they find this out retrospectively.

Average cat weighs 4kg, 5-5.5kg for a Maine Coon cat. Feed for the target bodyweight. Note that the Hills RD diet goes up to 6kg only on the packet for target bodyweights, and there are many cats well over this weight which need to be seriously slimmed down.

Cutting down the food is malnourishing to the animal. Hills RD is a balanced diet with low calories so that slimming is safe. 'Staff are not doing their job if they don't advise a diet in these circumstances of obesity.'

Kidney diseased cats live twice as long as kidney cats without the KD diet. For dogs, the statistics are even more significant.

There is a high enthusiasm for promoting good diet to puppies, but much less for senior pets who need advice just as much, and there are largely many more older animals than young ones.

Time management is a key issue for recommending diets/use of nurses and nurse phone calls to clients can help a lot to avoid time shortages in the vets' consultations and keep the advice up to standard with more time added.

How do you determine whether or not a patient needs a new diet?

Blood tests, ghp?

Weight comparison to chart of condition?

Pain assessment for arthritis? How?

Clinical conditions; eg: liver, heart, kidney.

Age : some owners want a pet to continue with the food he/she has liked all his/her life?

How do you determine whether a diet needs to be the same?

???Ideas??

What else do you need to make your recommendations effective?

Ideas???

## Paul R. Manning project report

ASHLEY GRAY FROM HILLS.

In a survey with AAHA, veterinary surgeons were asked why they did not recommend a diet/therapy. The results were:

Perception the client cannot afford it.

Time shortage.

Response from them when you talk to them = prioritising issues, veterinary surgeons often think diet is a low priority for example.

Veterinary surgeons are concerned about making the client feel guilty, and also they do not want to feel too much like a sales person. 'I would not be doing my job if I did not tell you everything your dog needs.'

Making loads of assumptions for old clients/old dogs. Old clients are often easier to deal with; older dogs are more difficult than puppies.

Need to ask open questions ;eg: what do you want from the service here?

SHARE SUCCESSFUL TECHNIQUE WITH OTHER TEAM MEMBERS.

The figures from the AAHA survey showed the following losses in compliance:

Diet recommended 73% uptake initially.

Diet purchased once 55%

Diet purchased 3 times 31%

Diet purchased more than 3 times 21%

Anything small that we can do to influence this can help to improve compliance a lot.

Clients in the Hills/AAHA survey said the reasons they did not comply or buy the diet included:

Lack of effective recommendation.

Did not know about it.

Too much information (TMI)

Conflicting messages.

Need or benefit not explained.

Lack of reinforcement by the team.

Cost : only 4% refused on the basis of cost.

Veterinary surgeons and including A ask too many closed questions, and not enough open questions.

$C=R+A+FT$

Compliance = recommend + aftercare + follow through.

Veterinary surgeon training is available from Hills.

Food recommendations should be specific, consistent, with reasons and benefits.

Best to write down/print a label for nurse referral, and followed up.

Most sales are made by staff recommendation.

Eg: FLUTD , post op td or id. Best for nurse to phone owner 2 days after kd because it is important that the cat or dog is eating the diet for the kidney problem.

### **The Vaccination Consultation**

15.4.05.

Why do you vaccinate?

What do you choose to vaccinate with?

What animals do you choose not to vaccinate?

How do you offer and deliver the vaccination?

### **How successful are you ?**

In % cases you have delivered your preventive medicine programme?

What factors contribute to that success?

### **What opportunities do you have?**

Before admission to hospital.

Routine annual vaccinations.

Lapsed vaccinations.

Others?

Why not?

Obstacles?

Your obstacles?

Owner obstacles?

GROUP MEETING : THE DENTAL CONSULTATION. 6/5/05.

Attended by A, D, E; rep from Pfizer Mark.

We discussed the questions circulated by A and then Mark from Pfizer gave a powerpoint presentation and issued some audiovisual aids for use in the dental consultations.

1a) D said she always mentions teeth, and believed it was irresponsible not to. E always mentions teeth if it is a consultation for vaccination, but if it is a presentation for a different primary cause she tends to mention teeth later.

1b) D : if mild tartar present, tends to discuss for a later date, advises try brushing. If bad gingivitis and tartar, will recommend 'do dental soon.'

E said in primary dental disease she would do this immediately. If a little bit of tartar, see in 6 months because E feels that client is more likely to come if they are given the opportunity to come when it suits them/ given a course of pre dental antitrope and a free choice of date. If teeth are rotting and owners are told this, they ant it done straightaway.

D and A said removing tartar is good demonstration and incentive for owners. E does not do this since she resulted in a broken teeth in one such demonstration in her last practice.

Scoring on vaccination card and on computer records. TIME MANAGEMENT and priority. Some owners like to be encouraged to clean teeth. The veterinary surgeons said they encourage ALL clients but some are not incentivised. There is a lot that the veterinary surgeons thought was priority dependent/depended on owner willingness to buy into the concept.

NURSE REFERRALS. D offers a choice of veterinary surgeon or nurse for a recheck in 3-6 months.

E said this depends on owner attitude.

HOW TO MOTIVATE THE CLIENT : discuss the bad effects of rotten teeth, draw pictures of neck lesions, use audiovisual aids.

## Paul R. Manning project report

HOW MANY CASES IN A DAY HAVE SOME SORT OF DENTAL PROBLEM? 70% of animals more than 3 years old have some form of dental disease. 24% of the ops board should be dentals (3-4 dentals daily is ideal for the prep room to deal with the volume and unexpected complexity sometimes).

PAIN is seen in animals rubbing their mouths, speedy capillary refill time. It is always useful to compare the pain felt by humans because clients do think about pain.

SOME OBSTACLES TO DENTISTRY : Price is sometimes an obstacle because dentistry is not usually covered by insurance. There is some confusion in the veterinary surgeons between the pricing on the computer of simple/complex/very complex dentals

A simple guide might be 'simple dental' = scale and polish + very simple extraction'

'Complex dental' = scale and polish + >6 extractions or 1 or more difficult extractions that take time.

'Very complex dental' usually means extracting carnassial teeth or k9 teeth.

Dental radiography is not often or even used rarely. D felt that a dental probe is useful in detecting lesions, and the radiography adds to time and cost with little added benefit.

ACTION: We will look at the indications for dental radiography and discuss again at a later date.

RESULTS OF GROUP : June 2006.

ATV for whole veterinary surgeon team has grown well in March 2005, especially C who has done very well and exceeded expectations to achieve £63 in March. Feb was 48.6. Jan was 46.6. April overall ATV =£51.46. May overall ATV=£53.55.

I have also discovered that for the past 2 months approximately the veterinary surgeons have been instructing the nurses not to price injections as they do them because the veterinary surgeons want to price them for themselves, and this is resulting in lost invoices for items that the veterinary surgeons themselves think 'should not be charged for or are not worth that price'(!) I have rectified this today by putting up a notice on both the veterinary surgeon and the nurse team notice boards to declare that items such as injections for hospitalised patients must be priced up as they are done or very soon after.

One client has decided to leave the practice for the reason of 'consultation fees' this week (ending 9.7.05). I have suspected the consultation fees would have an effect as they have risen, but my problem has been trying to get enough income from the assistant veterinary surgeons and getting them to take the workload off me. If I was overloaded with consultations at prices too low this would not enable me to generate enough income to employ assistants to help me. I had actually decided to put a freeze on consultation fees and vaccination fees from 1<sup>st</sup> July to encourage numbers of clients and work volume to increase. One of the other issues was that there seemed to be a limit to how much I could raise the ATV of the veterinary surgeons by training and encouragement alone; they had a ceiling above which they could not or would not go, hence the only way was to increase consultation fees. This has to be a good way of charging for vets' time, but is not always appreciated by clients. The effect of the DTI new rulings in October 2005 are likely to push consultation fees up and markups on drugs down. The other scheme I have had in place for 4 years now is the Astonlee Plan, which helps clients to spread their costs economically.

GROUP MEETING JULY 20<sup>th</sup> 2005 : Some issues and perceptions that can affect consultations and pricing.

Background.

Interesting point F raised today : he is feeling a bit disappointed he can't diagnose everything either due to client money shortage or unwillingness to refer....' Welcome to the world of general practice. I did point earlier that post mortems have revealed that doctors only get the diagnosis right in no more than



## Paul R. Manning project report

50% of cases of something like that. Also, it's commonly said that prognosis is more important than diagnosis, but F and C thought you can't make a prognosis without a diagnosis....another interesting point because we do that all of the time. Much of this is what we have experienced over the years, but seeing the young grads thinking about it brings some of my memories back from 25 years ago.

Paul

Having difficulty opening your MSc thesis but will keep trying.

I have a LIVE Fellowship position at the RVC and am doing the SPVS Masters course so am interested in many aspects of teaching and learning but my main project at the moment is "Assessment of Clinical Reasoning". Observation skills, physical examination skills and the ability to take a good history and pick out the salient features in order to make a diagnostic plan are aspects that I am trying to learn more about.

Another reason for trying to contact you was to put you in touch with Belinda Yamagishi who is in charge of Communication Skills teaching at the RVC – I have copied this email to her so she may well also be in touch soon.

Jane Tomlin

Assessment of clinical reasoning'.

A introduced this subject with the question 'How do you arrive at a recommendation and what do you do if the process cannot be completed? Process is typically : History/gathering information, clinical examination, explanation and diagnosis, treatment and prognosis, closure.' You can do a self assessment of your own clinical reasoning which is how you develop as a clinician, using your experience, testing a hypothesis of a clinical diagnosis with a post mortem where appropriate, developing pattern recognition of symptoms, which is all part of the reflective learning process.

A introduced and distributed copies of the new 'job descriptions for assistant vets'. Discussion took place about the definition of 'high quality consultations' referred to on page 2 of this document.

...'Consultations of high quality expected'...is open to interpretation. The medics have been developing 'consultation quality indices' (CQI's).

'If diagnosis is not achieved, prognosis is difficult...' said C and this was echoed by the other vets.

Clients don't necessarily want a detailed diagnosis because of the cost, and they often ask what the benefits might be if they are being offered further diagnostics. This is a natural question for a client to ask and so should not be intimidating to the vet. A finds these questions challenging and often rewarding to try to answer, challenging his /the vet's own knowledge and experience to good effect and with opportunities to learn and develop clinical skills. Learning pattern recognition of clinical symptoms is a key part of the development of a clinician.

Obstacles to achieving a diagnosis included lack of equipment and the ability in the team to use the equipment (eg: bronchoscopy/endoscopes : A pointed out we would need several different sizes of endoscope to get into cat noses, different sized urethras and airways, and the usage is not likely to be very great, and also many clients such as the one C described with the cat with airway problems the day before did not want a referral anyway...that leaves us with the problem of likely not being able to pay for the equipment unless we find the client wants us to do the job on our premises and not refer which is what A has found with the majority of Astonlee clients over many years).

A also pointed out that the number of Astonlee clients who were insured had risen from 15% to 25% which was significant and meant that ¼ patients were likely to be able to take a diagnostic pathway if it was recommended and in the best interests of the animal.

Lack of experience/lack of Certificate holders in the practice was another reason the veterinary surgeons gave for not achieving a diagnosis. The veterinary surgeons thought that experience would/should help interpret results (and clinical findings). A pointed out that this was part of the clinical development of the vets; not all experience is good.

Post mortems were useful in learning about the clinical symptoms and confirming or reviewing the diagnostic and treatment plan for future reference and clinical evidence building the skills of the vets. The veterinary surgeons said it was often difficult to get permission for a post mortem. A pointed out that a practice in Sweden did a very large number of post mortems, and C said all animals that died at Bristol Veterinary surgeon School were post mortemed. We could increase the number of post mortems with a recommendation and the reason of 'improving our knowledge for other animals in the

future.’ A had found that clients liked this reason, and some felt the loss of their beloved pet was being put to good use, but obviously not in all cases.

The veterinary surgeons were saying that they felt getting a diagnosis was really important to know how to treat the animal and give an accurate prognosis. They struggle with clients with no money.

The veterinary surgeons also felt strongly that getting a diagnosis was important to increase client compliance. A pointed out that the Hills/AAHA study recently found that the biggest reason for clients not taking a service was ‘the veterinary surgeon did not recommend it’. Price was only 4% of the reasons clients gave for non-compliance.

There are different ways of recommending even a post mortem ‘for the benefit of other animals’ for example. This does make a difference to the outcomes.

So ‘how do we define the job of the vet?’

The question is ‘is deciding with money considered to be part of the vet’s job by a) the vets, b) the practice?’ The veterinary surgeons don’t think it is, or looking after clients’ money. On the other hand some veterinary surgeons in other practices are the opposite and go out of their way to save their clients money...but are they really doing the best diagnostics and treatments for their patients and their concerned owners?

25.7.05.

D suggested we have a written/saved on computer notes ‘possible side effects or potential pitfalls following operations and signs to look for’ for clients. This would make sure we have told the clients and they have received this information.

28.7.05.

The problem with diagnosis is the client/patient wants the prognosis and often thinks the process and cost of diagnosis is not worth paying for. ‘IF DIAGNOSIS IS PART OF SUCCESS (your definition of success) YOU HAVE TO EXPLAIN TO SELL IT.

The doctor has the patient with a medical problem and psychology background.

The veterinary surgeon has the patient and client with psychology separated physically from the patient.

1. **OUT OF HOURS WORK IS NOT AN OPTIONAL EXTRA, NOR IS IT ‘JUST A BONUS FOR THE PRACTICE.’** It is an essential part of the business for the income generated, employing nurses, and providing a comprehensive service to our clients and patients. However, it does have to have a charging structure which is more than daytime work because the volume of work is much lower, and most importantly clients expect to pay a premium for this service. Fixed costs and pricing strategy. The need to follow pricing policy and why. Rechecks, injection fees, hospitalisation, blood tests, etc. We have fixed costs of a large wage bill for a start, which includes a very considerable amount for nurse training; rent and rates for this building providing services and making them available and desirable to clients. These fixed costs have to be paid for no matter what happens, so we charge clients accordingly. We need to be using the charges on the computer : cons oohs exam in hosp; higher hospitalisation day rates (See list of prices in appendix). One of the most important things we have to sell in our delivery of service is our TIME. Time management involves not only planning and using our time efficiently, but charging chargeable time wherever possible. Clients sometimes have a poor understanding of ‘charging for professional time’ which is why we sometimes charge more for x rays for example, but somehow or other we have to collect the money to pay our costs. 26.7.05. F asked about charging for OOR’s calls to wildlife : A advised phone RSPCA Leicester for a log number and charge the RSPCA ‘special call out fee’ + up to £50 treatment/euthanasia.

2. Protocols and recommendations. How are you recommending our services? How do you recommend prescription diets for conditions in which they are indicated? How do you use the protocols we have been working towards agreeing on for hyperthyroidism in cats, heart conditions, diabetes management, dental care (ABC). E said these are working as 'instructions/information sheets for receptionists about when to take blood samples etc.' but the veterinary surgeons tend to do their own thing with clinical protocols.

LIGNOCAINE PROTOCOL was reported as received and excellent from Mike Martin Cardiovascular referral centre, but this had already gone missing. (A had prepared a folder and hung it in the prep room for ease of access and use). C was going to ask for another copy.

3. Management of Long term CARE for patients. What cases do you recheck and when? How do you score in long term CARE of the following : a) pain management (Metacam, Rimadyl, Synoquin, Glycoflex, JD or other diet, etc), b) kidney management (Fortekor, KD diet, etc), c) heart disease (how and what do you use?), d) vaccination programmes (how strong and reinforced is your recommendation and how do you elicit and respond to client concerns?), e) obesity, f) colitis, g) diabetes, h) senior health care/wellpet? D started to describe how she recommends Glycoflex and deals with an arthritis patient. D is well satisfied with the results of use of Glycoflex on her patients. D normally used a trial of 7 days of NSAID's and then re-examined the animal. On the second consultation, the use of Synoquin or Glycoflex was reinforced and uptake quite good. More of the product was used if the arthritis was a bad case than if slightly lame or stiff. Cost of the product was an issue in just a few cases but not many.

Discussion took place about how the veterinary surgeons 'score or evaluate pain'. A suggested a 5 point question asking the client to subjectively score the terms of eg: difficulty getting upstairs, jumping into the car, playing, walking, interaction with people. This might help to gather information about the client's perceived pain that the pet was suffering. Sometimes this is considerably more when explored further as A found out recently when the client said the dog was 'a bit stiff' but when asked further the dog could hardly walk at times. A score may help to identify client concerns and then get a better compliance rate afterwards because the client has something to measure an association with pain. The veterinary surgeons were mostly not very keen on this, but D quite liked the idea. Their main concern was the time it might take and its subjectivity and validity.

Heart cases : progress was commonly assessed by the reduction in coughing and increase in exercise tolerance; also the quality of life as perceived by the client; animal more alert and keen on walks. The veterinary surgeons said they asked the owner their opinion/perception of the improvement or otherwise following treatment. Heart murmur grades are best done by the same person, because each veterinary surgeon may score them slightly different. The veterinary surgeons said it was difficult or impossible to put everything into boxes because clinical cases were individuals.

4. How do you think the clients see value in the second consult price for a) a 1<sup>st</sup> recheck for a cat bite abscess, b) a 1<sup>st</sup> recheck for a diarrhoea case in a dog that is all ok 24 hours after the treatment started? Discussion with C after the meeting (25.7.05) revolved around C's concern that a client did not want to come back for a recheck on her pet's corneal ulcer if it was costing a third consultation or even a 'consult tiny concession @£10+vat'. A asked if C felt she could refer to a nurse for this, and C said 'no because the nurse was not qualified and did not have the expertise to make a diagnosis and the clinical decision about the choice of treatment.' That was a good answer which needed to be explained to the client so that the client sees the value of what she is paying for. A commonly uses 'the reason I need to see you again for the corneal ulcer is that unless these completely heal there is a danger of losing the pet's eye, and I really do not want that to happen. I can see the ulcer with my examination aided by the ophthalmoscope.'
5. How do you think you present the value of long term medication for heart or musculoskeletal problems; and how do you think the client perceives this value?

6. Training. How has the training you have received/participated in at the practice helped you to improve your service; a) consultation skills, ultrasound.
7. Training. How have the external courses you have attended helped you to improve the service you deliver?
8. Health and Safety. Have you examined your attitudes to having your hands on the x ray films? Concern was raised again, and the views of the nursing team were 'concern that any hands were in the x ray beam.' The veterinary surgeons said they felt sometimes it was quicker and easier to hold the animal for an xray rather than wait for the next day for a sedative/ga, and some were barium xray studies in which sedation was contraindicated. It was felt that the risks were being minimised.
9. Dangerous Drugs. We have a bottle of Somulose missing and unaccounted for which we had to notify the Police about. Please make sure you fill in the Dangerous Drugs Book or we could find ourselves being inspected and called to account more seriously.
10. NURSING TEAM IN SUPPORT OF CONSULTATIONS. They have scored only between 2 and 6 'nurse vaccination clinics' per month since January 2005 when we tried to get this started. Feedback from reception and nurses is that many clients do not want to wait around for the extra time involved, except if it's for an id chip on the second puppy or kitten vaccination which is really excellent value and attractive. Another way of doing this job would be for the veterinary surgeon to see the client and then leave the room for the nurse to continue dealing with basic questions of worming, nutrition, id chip and so on. If there is a second room for the veterinary surgeon to move to the next consultation, this could work well and add value to the consultation. We might be able to try this on a Thursday which is 'discount vaccination day' and also this is usually when ops are a bit light and so more nurses should be available.
11. A nurse has left recently, but the biggest hole in the nursing team is Head Nurse off sick : she hopes to be back on Monday next week. We had zero luck with trying to get a locum nurse. We interviewed a recently qualified degree VN who used to be a junior with Astonlee in 2001. She is a promising candidate and she does not mind the night duties as explained to her.
12. The AGSS pump should be with us on Monday of next week : another frustration but we are getting there.

#### APPENDICES.

1. Out of Hours pricing.

JUNE 15<sup>th</sup> 2005. VETERINARY SURGEON TEAM at Astonlee.

Here are some developing ideas for discussion. Please add any comments or additional items that you feel we should discuss. Please write a sentence or two in your clinical learning section below.

GROUP : Consultations with clients who say they have no money.

What you believe in is important. Clients in this situation are critically challenging your true beliefs about what is best in the situation presenting.

How do you evaluate your beliefs? What examples have you got from the past 6 months?

Why do you hold those beliefs?

What do you think about offering a 'cheap clinic for 1-2 hours a week' to cater for this need?

GROUP : Consultations where bereavement and grief are present.

## Paul R. Manning project report

Clients may talk about money when they actually are grieving. Money cannot buy their dog back from terminal illness.

We veterinary surgeons need to get a receptionist into our consulting room to fill in the consent form and collect payment before we euthanase. What issues, if any, do you have with this?

GROUP: Rechecks. Why we do and need them. 10 steps to a recheck.

Building up the rechecks/follow ups not only 3-7days later, but also 3months, 6months, 12 months later for follow up ecg's, blood tests, reexams.

F, E, B and C are all working on producing protocols for the rechecks, which will be in bullet point format so that we can give them to receptionists and nurses to encourage them to promote them to clients, and support the veterinary surgeons in trying to achieve greater owner compliance.

GROUP : building your clientele.

C said 'this was difficult'. Why? What are the obstacles?

A's vision has been to work extremely hard to build the business with whatever effort it took, in order to provide enough work and income to the business to provide employment opportunities and develop a reasonable rota system for time off. In order to maintain this position, we need to continuously develop the veterinary surgeon team's skills in order to maintain client numbers (hence the need to measure this) and income from transactions (hence the measurement of average transaction values is important). The other opportunities created by this employment of more veterinary surgeons as we now have is that we can do more training and CPD which is vital for everyone's personal development as well as the development of the business. It is important to use some of the 'slack time' for reflection, reading, case discussions and CPD.

Key skills the veterinary surgeons need are:

1. Consultation skills which include the development of rapport and ability to bring clients back and develop the clientele.
2. Surgical skills to spread the work and enable both a sharing of this work and development of the ability of all the veterinary surgeons to provide emergency services in our out of hours rota.
3. Ability and understanding to provide the best service possible at Astonlee for our best and insured clients.
4. Understanding and ability to help animals whose owners have financial limitations.

A also wants to develop more internal referrals and more skills in orthopaedics, ultrasound/echocardiography, chemotherapy, soft tissue surgery, etc.

Clinical topics for discussion and development : ECG reading and interpretation, treatment of arrhythmias, GDV (key points that might improve outcomes), diabetes management, spinal case decision making.

A's clinical learning is at : echocardiography – can obtain the images, but cannot label them or do the measurements. Also we need a reference list of the measurements. ECG's need correlation with treatments.

Spinal surgery : would need to be better at diagnosing the location of disc lesions before attempting any spinal surgery. Has a book on the subject. Cerebrospinal tap and myelography for disc identification.

C's clinical learning is at:

D:

F:

B:

E:

## Paul R. Manning project report

**Process and Content.** There are ways we do things (eg: consultations) and there is content; eg: you could do a brilliant consultation with very little clinical content or accuracy (eg: comparison of ECG's is helpful from one consult to the next). We are aiming at developing and improving both our process and our content.

HILLS JD DIET.

H&S issues : radiation safety is very important, so no hands should appear on xray plates and no one should be allowed in the xray room while xrays are being taken unless suitably protected with clothing provided. The person pressing the button is responsible for this safety point.

HOSPITAL NIGHTS AND OUT OF HOURS SERVICE : Sleeping with the dog and charging for this level of care.

TRAINING GROUP : Paul's research.

I am researching the ways in which consultation skills can be linked to the outcomes and key performance indicators in veterinary practice. I would like to observe your consultations and interview you as part of this research. I would also like to interview your clients after consultations subject to their agreement and consent. I would also like to use the information gathered from focus group meetings to inform my research.

ETHICAL RELEASE FORM

This will be discussed at the meeting.

National Centre for Work Based

Learning Partnerships

Middlesex University

Trent Park, Bramley Road

London, N14 4YZ

Training Group Meeting August 30<sup>th</sup> 2005.

Cardiology course for F : B is covering the 3/4<sup>th</sup> Oct Wed afternoon to allow F to attend the course.

A Kennels complained about C over a case in which the dog died at our surgery, but during the time that the dog was boarding at the kennels whilst owners were away on holiday. The complaint was mainly about the use of the opening phrase 'What exactly is it that you want to know?' as the first piece of conversation C did over the phone. This came down to being too aggressive, although not intended to be, and C telephoned the kennels to discuss and apologise at the end of which clients happy. A had found the statement from the client 'veterinary surgeons shouldn't need any training in consultation skills' to be thought provoking, but he had heard this comment before. Clients need educating that consulting is not always easy and can be very difficult, and certainly needs training.

Weekend work : discussed collecting payment, referring directly to the account on the computer rather than creating another new account which is confusing, aim to collect a deposit before admitting to hospital if possible. It is important to give estimates wherever possible, although in a genuine emergency time may not allow for this at the time of admission so an estimate can be given at a later time but should not be forgotten. It is also best practice to record on the computer when a client is insured to avoid all the time involved in complex negotiations.

### **Clinical case recording on computer.**

Aim to make a working diagnosis, a plan, what has been said to the owners inc: phone at night or in the morning if the dog dies overnight, when next telephone call is to be received/made for a named vet.

### **Action**

Work on a template on the computer to save this type of notes for easy reference.

When going off duty, make sure that colleagues know about cases in hospital and imminently pending such as whelping.

## Paul R. Manning project report

Abbreviations in clinical notes: BAR=bright, alert, responsive.

INI=if no improvement.

INB=if no better.

EUA=evaluate under anaesthetic.

### **Action.**

Any other abbreviations to be shared.

### **Nursing.**

New Head Nurse is needed more in daytime than regularly rota'd on night shifts staying over at the hospital, so happy to keep this duty arrangement.

Consider adding another nurse to the team to restart the nurse night duties. This has the issue of training and making sure the night duty nurses have a minimum competence as follows:

Basic animal handling skills

Medication skills

Cleaning/cleanliness = not leaving animals in soiled bedding

Know normal behaviour of animals.

Drip out = phone duty vet.

Not scared of the dark, and able to be in the building on their own.

It would also be best to start off with a night nurse for weekend duties as a priority over a weekday night nurse to cover the oohr's at weekends.

PS:

New Practice Manager has been recruited and started work 14.9.05.

Next meeting agenda will include night duty nursing/recruitment and planning, night duty veterinary surgeon arrangements/charging for time and remuneration, consider possible changes to the veterinary surgeon rota to help relieve fatigue from nights on call.

### **Reflections (written) by Veterinary surgeon (D).**

The veterinary surgeon (D) who was instrumental in setting up the senior pet clinics in conjunction with the Head Nurse did provide some written reflections (July 2006) on how the consultation skills groups had helped her. She found it easier to encourage clients to bring their pets in for dentistry for several stated reasons as follows.

- *Fee charging.* The senior clinic was free of charge, whereas in a vaccination consultation the owners had already spent a fair amount of money on the vaccination and worm and flea products, and the veterinary surgeon felt the client was reluctant to spend any more, especially if the animal was eating well and 'appeared healthy'. The veterinary surgeon found that she often stopped recommending the dental treatment, especially if she felt the client was not receptive at this opening remark about the teeth tartar and decay, and most especially if the client mentioned cost and said they could not afford the treatment. The veterinary surgeon felt that a large number of clients just come for the vaccination, see the health check as a bonus rather than essential, and are unresponsive to suggestions about further recommendations for the health and benefit of the animal
- *Client expectation.* The veterinary surgeon also felt that clients attending the senior clinics were expecting to find problems such as dental disease, and when they were found by the vet, the client anticipated having to do something about it. The clients are also prepared to spend some time looking for ways of caring for their pet in middle to old age. The veterinary surgeon felt that giving a discount for the dental work helped to emphasise that the veterinary surgeon and the practice were concentrating on the need to provide the necessary care rather than the fee

- *Nurse support.* The veterinary surgeon valued the fact that in the senior clinic there was a planned consultation with the nurse immediately following the consultation by the vet. This served to support and reinforce the recommendations made by the vet
- *Free samples.* The veterinary surgeon felt that being able to give free samples of a diet available for dental care (Hills TD diet) was preferred by the client, and the veterinary surgeon felt that this was increasing the numbers of clients returning to the practice for a complete bag of the diet. (This was not documented or proven).
- *Rechecks 3-6 months later.* The veterinary surgeon asked clients to return for a recheck 3-6 months after the recommendation for dental care diet, but was unsure how many clients take up this recommendation.

#### **Reflections of veterinary surgeon C.**

The few paragraphs of written reflections from veterinary surgeon C included the comments:

- Consultation skills were important for a new graduate, and not much training or experience had been acquired before graduating
- The focus of the graduate was more on trying to diagnose and treat correctly, rather than focussing on the conversation with the client
- Not enough open questions were used, and this meant that the biggest concerns of the client were not always really appreciated or understood
- 'My eyes and ears have been opened up to the importance of communication within the workplace, both with staff and clients'
- Sharing how other veterinary surgeons deal with certain situations and communicate can give a boost to your own skills
- Patience with owners in taking big decisions and understanding disease processes has been identified as important and improved
- Giving small chunks of information works a lot better than giving a whole lot of information in one go, which can just confuse people
- Veterinary surgeon C felt that her communication with clients had improved over the past 2 years, and she felt happier and more confident in her conduct in the consulting room

#### **Reflections of the researcher worker.**

I personally identified with the tendency to charge the lower or 'tiny concession' fees in my own consultations as a result of the figures produced during the research, and changed my behaviour accordingly. I also recognised the difficulty in changing habits of a lifetime in general practice, not just from my perspective as a vet, but also from the perspective of the client who faced changing legislation on the pricing and delivery of pharmaceutical medicines, often without knowing or understanding what the changes really meant. Some pharmaceutical companies have been innovative in starting to change the ways in which they promote parasite control for pets by telling a story, and providing the veterinary surgeons and their team with new tools. This has included stories illustrated with pictures, which make the message easily understood by clients. The illustrated stories have a link to protocols agreed by the practice on what products should be recommended for a particular lifestyle description for the pet; eg: cat plays a lot outside and hunts, or a dog that is always on a lead and spends most time in the house



and garden. The importance of starting the consultation without focusing on the price of everything is crucial because this has a strong influence on the consultation, the way it is done, and potentially the outcome for the patient and client. The importance of concentrating my skills on dealing with client concerns about the patient/pet and ensuring that my recommendations are also focussed on the needs of the patient and concerns of the client need to be a much higher priority than the costs to achieve best care for patient and client. The consequences of including a cost benefit analysis of the recommendations too early in the consultation can result in a mismanagement of time, effectiveness and outcome of the consultation.

The veterinary surgeon who appeared to improve the most during the research period attended a non-clinical cpd event near the start of the period. This was organised by the Society of Practising Veterinary Surgeons (SPVS) for young vets, and this combined learning with a ski trip to Andorra.

The written reflections of the veterinary surgeon D showed very powerfully how important this process was, because in all the effort and time involved in delivering training and development for a whole year, measuring and tracking KPI's, there was no change in this vet's attitude and behaviour towards specific and key performance criteria. One of the most critical KPI's for the practice was the ability to recommend products and services. Another was to understand and implement good explanations to clients when they mentioned or asked about costs. The group meetings had specifically included discussions on these points, especially the point from the worker researcher that when a client asks about costs or money they are almost always wanting more explanation. This vet's reflections showed that she gave less explanation when a client mentioned costs, and also that this behaviour had not changed during the period of the research.

The issues surrounding the difficulties in charging restrained the worker-researcher from spending more time on training the veterinary surgeon D in areas of clinical skill that she desired, such as surgery. This was because the worker-researcher had to concentrate on bringing income into the practice. The understanding of the worker-researcher was that the consultation skills and the training were of critical importance because a prior knowledge of the practice finances and running the business made that very clear indeed. However, the perception of the veterinary surgeon D appeared to be that learning surgical skills was of greater importance, and proper charging was difficult and had an impact for her, which was detrimental to her career development and the ability to provide the best care. This was a disappointing finding for the researcher, but this did indicate that more work was needed on finding the best educational tools for the veterinary surgeons in the need for proper charging. There was a gap in understanding the links between the consultation skills, KPI's, and the career and personal development of the vets.

Veterinary surgeons can become more popular with clients than others if they do not charge correctly and in line with practice policies, or keep offering discounts, and this can have a very damaging effect on net profit. This was feared to be happening during April and May 2006. The numbers of dentals done during the initial period of the launch of the senior clinics did rise slightly, but overall the results tended to confirm that it was the strength of the vets' ability to consult, including the recommendation, that made the difference and not the ability to offer price incentives to the client. The numbers may have been worse had the senior clinics not been done.

The veterinary surgeon who promoted and did the majority of the free of charge senior clinics experienced a drop in her personal ATV during this period March to June 2006. However, the work could have added to the numbers of clients visiting the practice and also the goodwill and bonding of clients. This was a good example of how ATV's could be misinterpreted unless considered with other performance indicators.

The number of clinical observations made and communicated to the client added value to the consultation, and clients confirmed this in verbal feedback. For example a hamster with a broken leg was attended by the researcher worker, and the client valued this consultation much more highly than another consultation with a pet rat in which the client perception was that there was much less

explanation and advice given by another member of the team. The frequency of individual veterinary surgeons doing a Schirmer tear test for the condition known as dry eye varied quite a lot, as did other procedures such as blood tests, radiography, blood pressure measurements, and electrocardiogram (ecg). This was found in the focus group meetings, where the veterinary surgeons varied in how many times they would do a Schirmer tear test in a consultation from 'occasionally but only in the West Highland White terrier breed', to 'quite often in any breed'.

There was some variation in the use of time by the veterinary surgeons in the consultation. This was partly due to a variation in the individual vets' utilisation of nurses and their trust of the nurses to do the job unsupervised. The worker researcher favoured using the nurses to maximise the time he had available for talking to the client.

The difference in response to the training was clearly illustrated by the variations in the reflections of the individual vets, and in the difference in the ATV's during the period of the training and group discussions. There was a clear difference in response from the veterinary surgeons to the offer of audiotaping their consultations, with a strong reluctance and refusal in all of the vets. After some discussion, veterinary surgeons B and D agreed to the audiotaping. Analysis of the tape was done using RIAS, and veterinary surgeon B agreed that this had been a useful and informative exercise which helped her to think about her use of time, allowing the client to speak without interrupting him/her, types of questions used, structure and clarity of communication in the consultation. Achieving a good balance in the consultation was identified as important.

#### **Appendix 4 : Raw data from visits to practices.**

##### **Veterinary surgeon Surgery A : Interactive Meeting 17.3.05.**

**We assembled several veterinary surgeons together over lunch, and had a good discussion about consultation skills and what their definition of success was.**

Points made included:

###### Compliance

To fulfil the needs of clients and exceed their expectations.

Aim for AGREED best practice within the constraints.

Owner understands what the problem is and how to improve it.

Concise, friendly, compliment the client, supportive advice. 75% of consultations  
?50% of the time gold standard cannot be achieved because of constraints.

Assessing the client all of the time.

Judging clients.

Veterinary surgeon should recommend for the animal.

One veterinary surgeon recommended RD diet and referred the client to the nurse for further support and explanation.

They recognised the need for improvement in consulting : especially with the threat of the Competition Commission implementation in October 2005.

The practice had become very busy last year, and the veterinary surgeons believed there were untapped resources. They were aiming to make more of what they have.

Constraints : 'death by internal email in 7 number management'. Time management is difficult in and out of the consulting room. Some veterinary surgeons cannot write up at the time of the consultation as they go along and this poses a problem in them running late in appointment sessions.

Practice has 5 consults per hour with 1 slot to allow for catching up.

The veterinary surgeons have considered 15 minute consultations, but they wonder whether or not they would sell more products in the longer consultation. They need enough notes to follow up the consultations and sales, and they need to give perceived value in the consultation which is difficult to get.

Aim to get the client to go out with 3 pieces of information that they did not come in with.

Practice is doing a handout explaining...

Perceived value to the client is important to justify the fee.

Dear D,

Sorry I have not got back to you earlier : I have a really bad bout of 'flu/cold. Glad you enjoyed the visit. Thank you for your hospitality. I was pleased that your team were so keen to participate which made my research all the more interesting. It will take me a month or two longer to recover from the cold and compile some thoughts, but a few brief comments at this stage might be helpful. Remember I need to keep my comments generic and not naming names as part of the ethical agreement we made, which helps to ensure that no upsets are caused over what can be a very sensitive subject area for the vets.

The meeting before I started the observations was very useful and interesting, in which the veterinary surgeons shared their ideas of what success was in their eyes. That was good to share, and for the practice would be essential in developing your ideas about what you want to achieve by your two big changes being considered; ie: adding another veterinary surgeon and increasing from 10-15 minute consultations. I have achieved something that I am currently very pleased about which is to increase my average transaction values for my veterinary surgeons (all of them except 1) by over £10, and the receptionists have done the same for their own ATV's since I started in earnest with monthly focus group meetings on consultation skills since Feb 2005. I had the same 'resistance' as you found in your practice in veterinary surgeons not wanting to 'be measured' but I kept the measurements low key and concentrated on the issues of time management and areas in which the veterinary surgeons were interested in achieving more of their defined success in their consultations. This equates to a 25% increase in ATV with a 1% a month price increase (2% total), and no increase in time allocated to appointment slots.

If you increase your appt slots by 50%, can you realistically expect to get another 50% ATV? Or are you aiming at a different definition of success? One thing you could try is to give some veterinary surgeons who find it difficult to get their consultations completed and written up within 10 minutes an extra 2 minutes, or ask them what they think they need, and try to mould this into a 'practice training programme in consultation skills' which should be more achievable with the extra veterinary surgeon (not always easy in my experience with all the induction issues for a new veterinary surgeon etc).

One really nice observation that I made at your practice was that 'spending time listening carefully to the client at the beginning of the consultation and writing notes up while listening, assisted with time management and service delivery.'

I think your practice has a lot to gain from continuing to hold discussions about consultations and the skills involved.

Best wishes,

Paul.  
Practice P

I visited Practice P today and did observations of consultations and discussed consultations with the veterinary surgeons who were very enthusiastic and interested in the subject. They anticipate including more discussion at their next veterinary surgeon meeting soon.

There were some very interesting points arising, including:

1. 7 minutes is a very short consultation time, so anything that can be removed from the vet's time would be useful; eg: who books in the ops/why does it have to be the veterinary surgeon during the consult/why can't the nurses/receptionists be trained to do this...?
2. The use of an open question at the beginning of a consultation to invite the client to share their concerns while the veterinary surgeon types them onto the computer could save time in the overall consultation, as I have found in another practice where the senior veterinary surgeon does this and he is more time efficient than the junior veterinary surgeons who rush into examining the animal and don't start with an open question.
3. Giving the veterinary surgeons more time by getting someone else to book ops in, and encouraging a wider range of consultation skills such as the open question would have the potential to allow the veterinary surgeons some time to recommend vaccination in your new PDSA scheme. Without these skills, it is unlikely that much will happen in the consultation periods to proactively promote vaccination.
4. More consultation skills could include the use of different sets of questions for the client instead of repeating the same sentence recommending Stronghold without asking the client 'do you have any problems with taking up my recommendation?' for example.
5. In private practice the veterinary surgeons often say they spend 70% of their consultation talking about the client and 30% of the time on the animal. Your veterinary surgeons thought they spent 75% of time on the pet and 25% on the client, but one of the veterinary surgeons thought she was nearer 50/50 which from my observations seemed about right. So there is variation on this focus within this team, and this is likely to have a bearing on the outcomes and client compliance. This is a particularly important point when I was informed that last month they had 271 'no shows' for appointments, which was a source of quite a lot of discussion.

I have audiotapes of the consultations which I will analyse in due course.

I am organising a SPVS Roadshow on Consultation Skills for 12th January 2006 in Daventry, and I attach a flyer for this event. I will be sending the veterinary surgeons at Derby more information on this because they expressed a strong interest in it and requested the information.

This was a thoroughly interesting and rewarding day, so thank you, and thank you to all the team at P.

Yours Sincerely,

Paul.

**Practice S.**

**INTERACTIVE SEMINAR**

Participating vets: 5.

Final year students : 2.

Consultation Skills : exploring links to outcomes

Successful consultation : what is it?

Happy client

Happy senior partner

Happy junior partner

Clinical success : recovery or expected outcome

Bill paid

Size of bill

Rapport : chemistry : chat

Client bonding : repeat business and personal satisfaction

FULLY understanding client wants

Exceed client expectations : This practice uses survey papers to find out what they are.

**CARING**

Veterinary surgeon likes the animal and the animal likes the vet

Client recommends the vet/practice afterwards : the practice does surveys to monitor this.

Time management is important because all this has to be achieved in a short space of time.

Successful consultation : How do you achieve it?

Nice reception area. (Preconsultation client questionnaire for history taking could be a suggestion)

Greeting with a smile and using the name of the animal

LISTEN and use prompts discretely to encourage client to say what they are concerned about

Body language

Attention to the pet

Sift the information and focus on the animal if the client strays off into their 'life history or stories about mother-in-law.

Clinical examination should be good and thorough.

Explanations ; including estimates.

Talk/waffle.

## TIME

Summarise.

‘Were there any other questions madam?’

Book a revisit and closure of the consultation.

70% client focus....30% animal focus : The consultation starts with the client, then the pet, then comes back to the client again. The balance of the vets’ education is skewed towards animals with almost nothing on people.

‘How often have the veterinary surgeons asked themselves have they had success in their consultations?’ One veterinary surgeon refers to the numbers of dental recommends and monthly turnover figures, and self prompts to improve himself.

PM suggested using more pain assessment for arthritis than just ‘is he stiff in the mornings?’ A linear chart for the client to score perception of pain from zero to extreme could be used.

PROGNOSIS is experience driven. The veterinary surgeons all agreed that they do this all the time without an accurate diagnosis. There are links between prognosis and the rechecks.

The client wants to know ‘how long will it take my pet to get better?’

J felt uncomfortable about saying ‘Now what is OUR problem today?’ as E used to do when he was working in the practice.

The veterinary surgeons felt that the clients did not really care about them ‘Why should they?’ was a response from one vet. ‘When a client asks T how is he today?’ he responds or thinks to himself ‘why should they care?’ T thinks this is his sense of humour.

PM pointed out that the clients do care about their veterinary surgeons (judging by how they talk about them in the interviews afterwards).

SHAKE HANDS : Overcoming the gap between social differences between veterinary surgeon and client was discussed at some length. Sometimes J gives a client a hug if they are upset but this can go badly wrong or very well depending on circumstances and client feelings. PM pointed out that Ross Clarke has ‘touch the client’ as one of his 10 steps to a recheck in his book ‘Take your practice to the top.’

J said when he worked as a dustman it was always the council house tenants who gave him a tip, not the rich people. J discussed rich people are not necessarily more likely to want to spend money on their pets than poor people.

Professional image of the healthcare professional. This was discussed at some length in today’s Society make up.

FEAR OF REJECTION is a big issue for the vets. ‘When I have recommended vaccination, lumpectomy, dental.....I resist offering more’. PM said ‘if you focus on the animal’s needs, then give the client the choice, it works.’

**E, RCVS Dermatology Specialist.**

**Interactive discussion 24.3.05.**

E's definition of success:

Owner has a clear understanding of the condition.

Owner has a clear understanding of the treatment.

Owner has the motivation to carry out the recommendations.

The owner needs to be motivated. Set targets, share information, tell them what is possible.

Qualities of a good dermatology consultation are radically different to a surgical case because the surgeon is 95% of whether or not this is going to work, but in the skin cases the client is in control and also not so severely.

Dermatologists don't get tips or bottles of whisky in appreciation like the surgeons do. Dermatologists rarely see clients who are in a state of vulnerability. Whisky is perhaps the most concrete way of measuring client satisfaction.

Veterinary surgeon assessment is based on how pruritic the dog is, rather than the client's view.

If the dog stops and scratches in the park, it is very very itchy.

Ask owner on a scale of 1 to 10 where is the itch today? If we can keep him as he is today, would that be a satisfactory outcome for you?

Addressing owners' concern has not been a strength (in E's self assessment).

Flea life cycle needs to be understood and explained from a position of knowledge; eg: fleas come via the cat flap and food options. E uses precise clinical information to persuade the owner.

Thresholds for pruritis – components need to be kept below –

Clients to referral centres are more motivated than those in practice. A higher percentage are insured so there is an increase in diagnostic and motivation/treatment options.

'I believe that success depends on client motivation.' Veterinary surgeon can enhance, direct and focus their efforts. Cannot build from the ground up.

E uses eye contact to include the dominant and less dominant people in the consultation. There is a need to engage clients in conversation because they are then more involved and committed to the treatment recommendations.



Dieting the dog is arduous so needs motivating.

Clients need to have their heart in it. Must find common ground with the owner to motivate them. E adapts his behaviour to respond to client needs during the consultation. E feels he gets feedback by listening and observing the clients in the consult.

Non-verbal signals/body language affect delivery of nervousness of the veterinary surgeon to give difficult decisions. E encourages client to bring their partner in.

Cases can be very difficult to manage if a MAID brings the dog in.

Authoritative style is necessary in writing prescriptions.

#### STRUCTURE OF CONSULT.

Car park to greeting to history/eliciting client concerns to exam to diagnostic plan, treatment plan, share in conclusion and closure.

Number of revisits may be negative, but for E the number of revisits is something he considers a positive point in London. In Michigan repeat journeys are not an option. Impact changes the number of tests done at first consultation. Veterinary surgeon spends 2 hours a day on the phone supporting veterinary surgeons in practice.

CONFLICT is an issue between the veterinary surgeon and the referral vet; eg: clipping the fur from the dog.

Revisits help to refine management of the case. In telephone reviews, 2/3rds or 60% were back on steroids so motivation is better with revisits.

Revisits are especially important for difficult cases.

Many veterinary surgeons went to veterinary school not realising that the business is a people business.

Clients living close by the referral centre are better managed because the referral clinician controls the case and not the GP vet.

Dear E,

Many thanks again for allowing me to conduct some observational studies of your consultation skills. It was very interesting.

Just a few points on your 'paper for BSAVA on 'Management of the dermatology client'. I thought it would be easier to make a few comments on what I disagree with, because the majority of what you say I do agree with.

The opening sentence is I feel an inaccuracy because client education is a very important part of many consultations, and certainly is very high on many GP vets'

agendas. So I would recommend a modification of this opening. This leads into a descriptive paragraph about the importance of the welcome to the practice, which is common to all practices. The point that is often missed is the real and very powerful influence of the vet in that close encounter in the consulting room, and that is what my research is concentrating on. I imagine that some referrals from GP veterinary surgeons are as a result of perceived communication breakdown or loss of confidence for which the GP vet is looking for support from the specialist.

The major differences in emphasis in the dermatology consult are quite accurately described, although I would see them as part of the overall strategy and planning of a consultation utilising the Calgary Cambridge technique with 70 competencies as I outlined when I saw you. I think it is important to realise what the whole picture is so that the emphases are made with a holistic background and a completeness of the consultation.

You say <<it is important not to let the owner dominate the consultation.....>>>> I sympathise with this, but personally I prefer the 'approach that strives towards achieving agreement between the client and the vet. I feel that the emphasis should be on achieving an agreed compliance in the outcome, and so the effective sharing of medical information between vet and client is more to my liking, and more to my thinking on educating the veterinary surgeons that might be listening to you at BSAVA. My reasoning is partly based on the fact that many veterinary surgeons find they fear the clients and especially younger veterinary surgeons find this fear a real problem. Placing the words 'client dominance' in the lecture may well foster this fear and miss an opportunity to encourage the veterinary surgeons to be more proactive and engaging with involving the client to achieve a better outcome and better compliance.

I like your 'now and next' planning.

You said you thought surgeons get infinitely more thanks and bottles of whisky than dermatologists, but Interestingly an observation of your clients was that they placed 'achieving a diagnosis, improved diagnosis, better treatment, better understanding of the skin problem' all high on their reasons for valuing a consultation with you. They also valued your attentiveness and helpfulness and understanding of them in their attempts to find the best ways to care for their pets. The lady who's dog had the demodex was ready to give you a '5' if you could diagnose the problem, although she really appreciated the process you went through to get there. That was where a potential for exceeding client expectations and gaining warm appreciation was to be found in my view. I think the principles of this consultation technique apply to every consultation (if not quite all) at least at this stage of my research.

Hope that helps in your compilation of your talk to BSAVA.

Best wishes,

Paul.

**W VETS, 16.6.05.**

**Interactive seminar/discussion with 5 vets.**

**I used a flip chart to record the main points the veterinary surgeons made. The findings are as follows:**

**DEFINITION OF SUCCESS.**

**Infrastructure**

**Welcome greeting**

**Smells**

**Front of house**

**Request a good history**

**Good clinical examination**

**Holistic approach**

**This is all necessary for care, listening, eliciting client concerns.**

**One veterinary surgeon felt that she needed training in ;managing her attitude' which could influence her body language and communication, especially when tired.**

**Talk to the animal**

**Stroke the animal**

**Eye contact**

**Body language**

**Take time not to be rushed**

**Clear explanation in simple language**

**Summarise**

**'Ask if client has any questions' is better than 'do you understand?'**

**Approachable : care not to belittle the client and make them fear to ask.**

**Time management : 1minute to call client in, 10-12 minute consult, 2-4 minutes writing up the notes.**

**Nurses are not involved in the consultations in this practice much at all. The practice might take up a suggestion that they try using the nurses at times and monitor the impact. The veterinary surgeons agreed that the variation in time structure was present in their consultations depending on what the presenting problem was, and they varied the use of time within their 15 minute allocation.**

**REASONS FOR NOT RECOMMENDING.**

**Assumptions**

- mainly about money and client's ability or willingness to pay.
- Worry about the risks/eg: heart condition, for the veterinary surgeon and for the animal and for the client.
- 'It would be useful.....' veterinary surgeons said OK to this
- 'I think we need to...' veterinary surgeons said OK to this.
- 'We are going to do this x ray for your pet....' Veterinary surgeons said no to this because they thought it important to give the client options.
- 'I think it's important to.....' Veterinary surgeons accepted this.
- Personal interest or that of their colleagues, or the lack of it.
- Synoquin and Optimune were compared in my own practice at Astonlee, and this very much depended on vets' personal interest in either eyes or arthritis as to whether or not they recommended the product.
- Lack of knowledge or expertise.

**CLIENT                                  VET                                  PATIENT      all have needs.**

**Veterinary surgeon needs to motivate the client to deliver the care to the patient.**

**IN SUMMARY, MY RECOMMENDATIONS TO THIS MEETING OF VETERINARY SURGEONS WAS TO :**

- 1. Define success in consultations.**
- 2. Reflect on this.**
- 3. Measure it.**
- 4. Repeat the cycle.**

## **DISCUSSION OF COMPLIANCE**

**I talked to the veterinary surgeons about achieving compliance and the Hills survey in which 55% of compliance was lost in the vets' consulting room, and most of the reason why was because of a failure to offer the services or products.**

## **Appendix 5 :Raw Data from observations and semi structured interviews.**

Notes on the observations of consultations and the interviews afterwards

Practice A.

1. Veterinary surgeon R (in coloured shirt) Client with white cat.

‘What did the veterinary surgeon tell you was the problem? Therefore to Veterinary surgeon ‘as a result of the consultation, what do you think the client understood the problem to be?’

Teeth care/oral care diet 25%/TD diet 75% Annual booster vaccination  
Sunblock on cats ears in summer  
Flea control = Frontline being used frequently No problems  
Weight=5.55kg.  
Wormers available from reception.

‘What was the treatment the veterinary surgeon said was needed? Therefore to veterinary surgeon ‘what treatment (in detail) did you recommend?’

No discussion.

‘What was the treatment the veterinary surgeon said was needed? Therefore to veterinary surgeon ‘what treatment (in detail) did you recommend?’

Oral care and wormers

‘To veterinary surgeon what was the prognosis? To client what did the veterinary surgeon say the outcome would be in terms of your pet getting better?’

No discussion

‘How do you think the client would rate you on the following criteria:  
From 1 not very helpful/supportive to 5 excellent, really supported me and my pet.

‘Why do you think the veterinary surgeon was so helpful?  
Very good, good advice, friendly.

2. Veterinary surgeon young lady K Client Mother and daughter in law

White Westie puppy,2kg,10weeks old

‘What was the problem?’

Lion Jaw/craniomandibular osteopathy  
Steroid treatment

Conjunctivitis both eyes, very thin

‘Name of condition?’

Lion jaw

‘Treatment’

Steroid high in morning, low in evening  
Aiming for vaccination in 7 days time  
Needs protection and socialisation  
Needs more steroids  
Puppy mini biscuits Hills diet.  
Include overeating, strongly recommended.

Drip, steroids.

‘Prognosis’

Very pleased with progress, good progress  
And response but phases likely in the  
Future, will be lucky not to have problem  
In the future, side effects.

Life long; Steroid

‘Rate the vet’

4.5, very good.

‘Why so helpful?’

Went better than expected, had expected it to be  
A bit awkward, did not quite know what was  
Wrong, client would not give permission to do a  
Ga and xray, very worried about CASH, thought  
Client may want puppy put down, couldn’t open  
The mouth

9.30pm update phone call, very  
detailed explanation.

3. Veterinary surgeon K

Client : Pekinese cross,  
male, 7.4kg, boostervaccination and checkup.

‘Problem’.

Itchy left ear. A little hazy in eyes.  
A little tartar on teeth, strong pulse,  
Relaxed abdomen, heart sounds normal.

Left ear : shy away when brushing  
15 years old in May, DEAF. Good  
Appetite: diet=chicken/tinned food.  
Doesn’t like car rides = gets worked up in  
cars even if owner sits with him. Never  
had any treatment; nothing seemed to  
work, never tried tablets.

‘Name of problem’

No pus or wax in the Right ear.  
Left ear very inflamed at top, itchy on  
Exam=very red/inflamed, probably a little  
Hair has irritated it.

No pus, no inflammation, a hair caused  
irritation.

‘Treatment’

Ear drops to cool it down and antibiotic.  
Content to sort the ear = 5-6 days.  
VACCINATION : (note the certificate has  
No health assessment)  
Frontline flea control continuing.

Ear drops.

‘Prognosis’.

Keep an eye on the ear.

7 days. Has had the same problem  
before.

‘Caring score’

3.5

4+

Happy to get the ear treated. Veterinary surgeon felt she  
Did not cover the diet. Difficult to make  
Herself heard above the noise of the dog  
With an old owner. Veterinary surgeon felt owner perception  
Was distressed because had waited for 10-12  
Minutes as the veterinary surgeon was running slightly late.  
Did not use the receptionists to advise on diet  
Because of a fear of contradiction : veterinary surgeon was  
Happier to use a nurse for this.

The worst bit is waiting to see the  
veterinary surgeon because the dog

gets a bit upset,

more so since becoming deaf.  
Good examination,checked for  
owners concerns. Dog sometimes  
runs around a room when he  
comes back into the house:once a  
fortnight for past month,walks out  
once a day:owner happy with this.

INTERVIEW WITH THE VETERINARY SURGEON AFTERWARDS.

Veterinary surgeon uses nurses for some cases after convincing owner. The  
receptionists are busy doing training in Hills nutritional products, but not sure about  
the practicalities.

She scored herself low because she felt she should be telling the client more about  
feed and wormers but does not want to push too hard, but something tells her she  
should have done more.

Covered the basics : client reasonably happy : covered clients’ concerns, not sure she  
got all the worries out of the client. She felt nervous about being watched.

She would like a health check on the vaccination card because some clients query the pricing of a vaccination which is actually for a 'vaccination plus a health check.'

4. Veterinary surgeon S (Lady vet).  
mouth tumour.

Client : Bichon Freis, 6.2kg,

'Problem'

Small piece of jawbone exposed, tumour  
pushes tongue over to one side. Normal  
Submax glands, no pain in jaw, gained 100g  
Bodyweight.

Eating quite well, slightly mucky  
eyes. Much better on the  
painkillers and less discharge, less  
saliva, less blood from mouth.  
Likes chocolates, licks a lot after  
Eating.

'Condition name'

Did no biopsy or xray, was treated for  
Osteomyelitis post dental = definite bone  
Cancer of the jaw.

Bone cancer in jaw, xray not necessary

'Treatment'

Pain killers and antibiotics. Recheck in 7 days  
Happy with the treatment.

Antibiotics for bone  
infection, antiinflammatories.

'Prognosis'

Quality of Life good, playful, no blood  
From mouth and no pain.

More good days on the pain killers. Owner  
keen on weekly checkups to carefully  
manage the case. Weekly checkups with  
reviews.

Potentially may change, judging how his  
pain and quality of life are doing. If he  
seems in pain, need to review. (c7days).

'Care score'

4

4.5

Guarded prognosis.

Gets on with the clients well, clients have  
Been quite open with the vet, easily talks  
To the client, client happy to ask and discuss  
Openly any worries; client is going to lose  
Their pet through cancer  
surgeon practice all

Client has attended this veterinary

his 15 years of life with the pet, very  
good, always someone available,  
really nice and friendly; say like it is  
and put the dog first.

Has discussed options of surgery in previous



Consults.

#### DEFINE A SUCCESSFUL CONSULTATION.

Animal : making a complete examination, correct differential diagnosis, treatment plan.

Client : getting on with them, understanding exactly what you have done, understanding the treatment plan, leaving having answered all questions client has, trusting YOU.

Issues : some clients don't interact very well.

5. Veterinary surgeon R.  
chair by the vet,

Client : Elderly given a

12 years old cat, 4kg bodyweight.  
Diarrhoea, especially evenings.

'Problem'.

Polydipsia, d+v+

Polydipsia = drinks a whole cat bowl +  
possibly outside water.

V+ furballs, has eaten today, nice coat.

A little thin along the spine

Dramatic increase; very very thirsty in

Mornings. Had a blood test 1 year ago at

Time of a dental = can be kidney problems

Getting worse.

'Name of condition'.

Kidney needs to be looked at.

'Treatment'.

Diet is not the best at the moment for

This cat = Whiskas which contain high levels

Of salt and protein = not good for kidneys.

'Prognosis'.

Need a blood test 12 hours starved tomorrow am

(starve from 10pm tonight), leave water down.

Blood test to ascertain prognosis.

Owner worried she cannot  
replace cat in her FLAT.

## Appendix 6 : Raw data from seminars and SPVS Roadshow in consultation skills.

SPVS Consultation Skills Roadshow, January 12th, 2006.

Staverton Park, Daventry, January 12th 2006 (rev mld 281205)



# What do your Clients Hear?

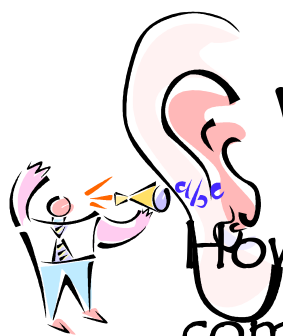
How to improve your consultation skills, client compliance, clinical outcomes and profitability.

## Programme:

9.00am	<b>Registration and coffee.</b>
9.30am	<b>Introduction</b> - The challenges and how we can develop our skills to meet them. Paul Manning.
9.45am	<b>Compliance</b> - Do clients do what we say? Ashley Gray MA VetMB PhD MRCVS Senior Veterinary Business Advisor Hill's Pet Nutrition
10.30am	<b>Consultations in modern veterinary practice</b> - what are the problems and the potentials? Paul Manning MA, VetMB, MSc(VetGP), MRCVS.
11.00am	<b>Coffee.</b>
11.30am	<b>What are we doing to improve consultation and listening skills in our undergraduates and new graduates.</b> Carol Gray , BVMS,MRCVS Lecturer in Veterinary Communication Skills, University of Liverpool.
12.00pm	<b>'The arthritis consultation - how to make it work and make it pay'</b> Jolian Howells (Senior Product Manager) and Ann Robinson of Pfizer Animal Health
12.45pm	<b>Lunch</b>
1.45pm	<b>The consultation</b> - where are we now? Small group work/large group discussion - Dr Mei Ling Denney
2.30pm	<b>Consultation skills and the medical profession</b> - Dr MeiLing Denney, RCGP Problems in doctor patient communication, how consultation skills affect outcomes.
3.15pm	<b>Exploring consultation skills in more depth.</b> Small group work/ large group discussion - Dr Mei Ling Denney
3.45pm	<b>Tea</b>
4.00pm	State of play in RCGP assessment of GP consultation skills - Dr Mei Ling Denney (showing a video consult)
4.30pm	<b>Towards a quality control index and using reflective learning-comparisons with the medical profession and the future of veterinary CPD.</b> 'Current research that may provide tools and methods to analyse and help improve consultation skills in vet practice.' Paul Manning (Learning Sets, seminars, observations and post consultation interviews, audiotapes).
4.45pm	Questions and concluding remarks. (Panel)

Kindly sponsored by:





# What do your Clients Hear?

## How to improve your consultation skills, client compliance, clinical outcomes and profitability.

Need to understand why different veterinary surgeons produce such different consultation outcomes?

How to increase profits from consultations.

Need to improve your consultation skills?

How to manage your time effectively with clients during consultation.

Need to develop a training programme in consultation skills?

How to minimize complaints from events in the consulting room.

### **Programme to include:**

**What are the Problems and Potentials with Consultations in Modern Veterinary Practice.**

Paul Manning MA, VetMB, MSc((VetGP)MRCVS

**Compliance: Do Clients Do What We Say?**

Ashley Gray, MA, VetMB, PhD, MRCVS (Hills)

**How Assessment Has Helped Develop Consultations in the Medical Profession.**

Dr Meiling Denney, FRCGP, DCH, DRCOG, MMedSci, ILTM, who has worked for the past 10 years with the

Royal College of General Practitioners in the field of assessment.

**The Arthritis Consultation – How to Make it Work and Make it Pay**

Jolian Howells (Senior Product Manager) and Ann Robinson of Pfizer Animal Health

**What Are We Doing To Improve Consultation and Listening Skills in our New Graduates**

Carol Gray BVMS, MRCVS, from NUVACS/Liverpool Vet School

### **Interactive sessions:**

‘What do you do?’, ‘How and why do you consult?’ and ‘How could you do it better?’

For further details of the programme please contact the SPVS office at the address overleaf.

### **Venue and Date**

Wednesday 12th January 2006 - Staverton Park, Daventry

Cost: £140 plus VAT for SPVS members,

(£85 plus VAT for second delegate from same practice)

£150 plus VAT for non SPVS members



**SPVS Roadshow : Consultation Skills : Jan 12th 2006, Daventry. (Short article in Veterinary Business Journal December 2005)**

Recent developments in practice have reinforced the need for us to improve our understanding of what we do in our consultations. Making the most of the consultation to deliver best medicine means we need the right skills. Ensuring that the whole vet team performs optimally means we need to find ways of delivering the training to facilitate greater uptake of the skills.

Consultation skills are an essential part of our range and they do affect our ability to achieve best practice and client compliance.

The day will include some of the background research, some tools and models for use in practice, and some training from a very experienced GP Doctor (Dr Mei Ling Denney) who has been assessing and organising workshops for GP Doctors for the past 10 years.

Paul Manning will talk about the findings in his MSc and Doctorate research in veterinary practice, and Ashley Gray of Hills will illustrate the Hills Survey done in conjunction with the American Animal Hospitals Association in the USA on compliance.

Carol Gray of Liverpool University Vet School will talk about what the Universities are doing to improve and increase the training our undergraduates receive and how this can help in practice.

Jolian Howell and Ann Robinson of Pfizer will illustrate some tools for making the most of the chronic long term case in a consultation, with particular reference to arthritis.

Dr Mei Ling Denney will give two talks in the afternoon about the importance of developing consultation skills, drawing on her experience with Doctors. Mei Ling will also take us through an interactive workshop in which delegates will explore aspects of consultations and will acquire ideas and skills to take back to their practices.

SPVS has been promoting and developing the interests of practising veterinary surgeons for over 70 years. This is a day when you can learn more about the people skills and consultation skills that can help to make the most of your profession.

## SPVS Consultation Roadshow : Presentations by Paul Manning.

Introduction : An opportunity to experience some reflective learning of great value.

### The Agenda :

The issues, where are we now?

Tools available to us

Interactive workshops

Research results and quality control

Factors with impact on the consultation

Practice economics

Employment of staff

% animals insured

CC and other Government regulations

Declining farm animal sector and SA nos

Increasing client demands and competition

Veterinary surgeons moving jobs

### Open Mind

Have you got a blank sheet of paper or is your sheet cluttered with preconceived ideas that could hamper your progress?

A successful consultation

Handout for workshop number 1 (afternoon)

This is a key to today's seminar and the journey we hope you will take in your reflections.

### Our Unique selling point (USP)

'According to a recent consensus statement on physician-patient communication (Simpson et al 1991), 'effective communication between doctor and patient is a central clinical function that cannot be delegated.' Stewart, M.A. Can Med Assoc J 152, (9), 1423-1433.

### Models

There are lots of ways of looking at a consultation and as many different models.

Safari model (Steve Garner USA) gives clients 45 minutes in a consultation, but the vet only provides 5 minutes of that time.

Diagnosis is not part of every model, some focus on the exchange of information.

### The 'inner sanctum'

'The 'inner sanctum' is a private or secret place to which few other people are admitted' Oxford English Dictionary.

This seems to describe how many veterinary surgeons view their own consultations.

This sensitivity needs to be addressed to make progress.

### Is communication our clients' problem or our problem?

Svarstad in a PhD thesis in the USA 1974 was one of the first to challenge the previous paradigm that 'the problems doctors have are all with their patients', and change the hypothesis to 'maybe the problem lies with ourselves, us doctors?'

### Meetings between Experts

## Paul R. Manning project report

Book by Tuckett, 1985. The physician is the 'expert' on the medical science, whereas the patient/client is the 'expert' on the body or animal from their intimate knowledge and observation.

Alternatively the Agate stone

We could choose to buy an Agate stone fossil. Agate Geodes are ancient volcanic bubbles, which partially filled with crystal, leaving a beautiful crystalline hollow centre. Geodes are thought to help with effective communication skills and are believed to be good for the nervous system.

Opportunities

Many types of consultation

Many different models can be applied and analysed;eg: Calgary-Cambridge,

Approaches to the opportunities include:

Seminars 'defining successful outcome'

Observing consultations/audiotapes and analysis

Monthly team meetings to raise awareness of opportunities (taken and missed)

Consultations in modern veterinary practice: what are the problems and the potentials? 10.30-11am

Problems include:

Problems in performance

Some veterinary surgeons are better than others in performance and rechecks

Some veterinary surgeons are popular for the wrong reasons;eg: they don't charge properly, or they allow clients to get their way over rechecks.

Veterinary surgeons vary in their enthusiasm for different consultations. This + knowledge affects uptake of clinical services.

Complaints to RCVS/VDS are 80% on communication, consultations.

Problems in skill deficiencies

Responsibility avoidance

Follow through failure (rechecks)

Time Management failure

Planning failure

Failure to elicit client concerns

Closing the consultation

Potentials

Increased ATV's

Better work sharing between vets

Increased turnover

Increased profit from better use of time

Increased profit from better use of opportunities and compliance

Greater job satisfaction, self-motivation, renewal of enthusiasm.

Time Management : the reality

This is a huge issue.

Being a professional includes managing our professional time which needs to be structured and charged for.

Results of research

## Paul R. Manning project report

Define successful consultation : after lunch, important not to prejudge your ideas.

Observations of consults:

No vet in 100 consults gave a written health assessment/checklist for the client in a vaccination.

MSc research ref: [www.vetgp.co.uk](http://www.vetgp.co.uk)

MSc Research

Doing the project

Focus group in my own practice

Literature search, study of current knowledge.

Survey by questionnaires :vets, clients

Semi-structured interviews in 4 different practices from Kent to N.Wales

Results of questionnaire to vets

Results of questionnaire to vets

MSc research

Comparison of veterinary surgeons and clients ranking 8 values.

The veterinary surgeons rated clinical skills as the most important in the price of a consultation, followed by communication.

Clients valued Communication and caring as the most important, with clinical ability second.

This was triangulated in the semi-structured interviews

MSc results

Results of Dprof research

Audiotapes of consultations

Time to interruption: low=worse outcome and time management; higher=better outcome and time management.

Chat/too much social exchange causes poor outcomes;eg: wrong vaccine,fail to recommend

Results of research

Post consultation interviews

Clients love their vets,always scored their veterinary surgeons higher than the veterinary surgeons themselves.

Veterinary surgeons underscore their consultations, 'especially when it's a simple vaccination.'

Veterinary surgeons can fail to give the best treatment by making assumptions about the client,eg:xraying their wallet, or assuming they won't want the diagnostics or diets without explaining the benefits and giving them the choice.

Towards a quality control index for consultations 4.15-4.45pm

Have measured

Multifactorial approach

What to include

Monthly training meetings for the veterinary surgeons in which consultation skills are discussed proactively. This needs to be ongoing, not just a one off meeting.

Data collection techniques entering the 'inner sanctum'. Not just relying on outcomes.

Analysis :processes need to be proactively involved in contributing to developing consulting skills.

Links to KPI's may be useful but:

'Open mind' is essential to *notice* things that make a difference

Results of research

Definition of a successful consultation : summative overview from different practices

'To fully understand and fulfil the needs of clients, and exceed their expectations' Owner has understanding and motivation

'To aim for AGREED best practice within the constraints'

'Happy clients, happy vets'

Ratio of client/animal patient

Greeting, client contact/shake hands, rapport/chat, sharing medical information, good exam, listening, professional guidance/explanation, planning('now and next'), eliciting client concerns, good estimates, time management (short time available to achieve a lot), checking understanding and closure

'Bill paid, size of bill'

Definitions of a successful consultation from practice visits

Caring (talk to the animal, stroke the animal, eye contact, body language, take time not to be rushed, be approachable)

Clear concise explanation

Summarise

Nurse involvement varies

Definitions of successful consultations from practice visits

Attitude of the vet (eg:enthusiasm) affected by stress, fatigue, interest level which affects behaviours : one vet recognised a need for training in managing this.

Definitions of successful consultations from seminars

Paul's personal definition

My definition of a successful consultation

The definition I have constructed is 'the effective sharing and imparting of medical information relevant to the patient, and addressing the concerns of the owner.'

I will know when I have been successful in my Doctorate research when I have accumulated data and analysed it in ways, which convincingly demonstrate linkages between the implementation of consultation technique and clinical outcomes.

Roter Interaction Analysis system (RIAS): Coding of audiotapes

Socioemotional exchange

Task-focussed exchange

Global affect ratings

Adaptations

Contextual elaborations

Proficiency checklists

(See handout)

RIAS : approaching the vets

Some are keen, many are fearful especially in relation to their perception of 'bosses' KPI's'

Preparation with talks and discussions is essential

RIAS : the analysis

Bias can be introduced by the researcher because of previous experience and or lack of familiarity with the scoring system.

Links between KPI's and consult skills



Time management achieved through a better focus and listening skills is likely to produce better financial performance and delivery of clinical services. (Ref: Dprof observations and audiotapes).

Skills in delegation to nurses often link to better performance. Veterinary surgeons vary in this.

### Analysis of Feedback from delegates at the SPVS Roadshow

	Presentation	Content	Comments
PAUL MANNING	74	72	Content of overheads should support presentation – not the other way round. I resent the suggestion that experience is irrelevant and consultation skills is a new subject to me. I've been doing this for 161/2 yrs
ASHLEY GRAY	86	80	
CAROL GRAY			Not relevant to veterinary surgeons who are in practice, but was interesting. Far too long- little relevance Probably the best speaker, though of limited use
JOLIAN HOWELLS ANN ROBINSON	67	67	Too long
MEI LING DENNEY	91	82	Stimulating to have medical point of view Very interesting discussion Most useful part of the day.
HOW WOULD YOU RATE THE WHOLE DAY?	77		Afternoon particularly interesting
DO YOU FEEL THE EVENT WAS VALUE FOR MONEY?	Yes – 16/19 No – 1/19 No response 2/19		
VENUE	<u>Facilities</u> v. good Good Good room – IT failed when needed Good apart from electronics problem Good Very Good Good V.G. Vg Good Excellent Good Good	<u>Location</u> Good – central Good for us – near Too far from train station Poor instructions to get here and poor signage when arrive at the complex Excellent central location OK Acceptable Good Directions – doesn't give any indication of time/distance motorway junction from venue. OK – no further north!	<u>Catering</u> Best tea & coffee facilities I have had on a CPD course Excellent Excellent bread and butter pudding Poor coffee & break facility. Lunch 4/5 Good Good V good Good V.G. Vg Excellent Adequate. Poor communication

Paul R. Manning project report

Accommodation Only one person stayed, but said it was very good.	Good	Awkward Far too far south Long drive (from Harrogate) Easily found. Would appreciate something a bit further north. Good	Fine Good Good – vegetarian food the usual pasta bake. Can no-one come up with something more interesting?
WHAT DID YOU FIND PARTICULARLY OF VALUE TO:	<u>Yourself</u>  Stimulated me to re-organise how we run the ongoing assessment of our veterinary surgeons and myself Made me think how I communicate Practical skills, useful phrases you can use during consultation, consultation models. New ideas for some questions to clients Making me think about things from the clients point of view Need to reassess how I consult Dr Denney provided the only insight into how to improve the way of thinking	<u>To talk to your colleagues at the practice</u>  Cons skills discussion Useful in helping new graduates especially Ideas for consultation skills training Need to have vet protocols for approaching common cases Continuous care programmes Observe each other's consults	<u>Your practice</u>  We can all learn from each other Limited value due to the make up of my practice Care programmes Pet care programmes Hope to improve profitability and client satisfaction Extended care programme
IF YOU COULD CHANGE ONE THING TO IMPROVE THE CONTENT OF THE DAY, WHAT WOULD IT HAVE BEEN?	Even more interaction in groups – was good Printed notes of slides should have been made available Broaden the areas covered to reduce repetition Less medical emphasis – more on selling skills, use of body language, words and expressions used. More DVDs, videos More discussion of videoed consultations Group discussions- most enjoyable and useful part of the day. Don't feel got the message of the arthritis lecture – couldn't see projection as lecturer standing in front of screen on occasion. Examples of asking non threatening questions Venue location Not sure if the small group sessions are the best use of time. No – it was very good to have discussion after lunch to stop the post – prandial snooze! More practical, less theory		

### **Reflections from a delegate.**

Here are some extracts from notes and reflections written by a delegate at this Roadshow:

### **Tasks to be accomplished during the Consultation Process**

1. Preparation - read through notes first before starting
2. Building rapport - set each other at ease
3. Identity problems - Client problem list
  - Vet problem list after full History taking and Clinical exam
4. Reconcile the above so that both sides agree on the range of problems that need addressing.
5. Plan of action
  - Prioritize problems
  - Give range of options
  - Range of options to be consistent across the practice
  - Give opinion and guidance on mostly suitable option for this case
  - Give adequate time for client to decide
  - Prepare estimates as needed
6. Discuss likely outcomes –
  - Does the client understand the prognosis
  - **Are their expectations realistic**
  - Are risks explained and accepted?
  - How long will it take?
  - How serious is it?
  - Do they understand the costs involved and the time involved.
7. Agree the plan
8. Implement the plan
9. Arrange follow up
10. Summarize to client and if possible get them to summarize back so that both sides are in agreement

What Helps the above

1. Time - complex cases may need the above to be spread over several appointments, or the use of a double appointment, or admission to gain the time needed.
2. Describe the benefits to the client rather than the features. A blood test is a feature, the benefit being that a diagnosis can be made and then appropriate treatment given which will improve quality of life and make patient feel better etc
3. Confidence in your recommendations and an ability to communicate this to the client in terms that they can understand and clearly see the benefits.
4. Discussion with colleagues in friendly, constructive, blame free, safe environment
5. Understand client needs and give them what they want, don't make them feel guilty, don't cast judgement.
6. Follow up phone calls from vet or nurse to monitor and reinforce recommendations and treatments, provide additional help.
7. Demonstrate how to give medications, involve nurses
8. Clear explanations in non technical terms
9. Stress importance of animal welfare
10. Clarify client expectations

**CARING IN THE CONSULTATION : Paul Manning, MA, VetMB, MSc(VetGP), MRCVS**

**A SEMINAR FOR THE VETERINARY CHRISTIAN FELLOWSHIP, FEB 2005.**

It is not what we do that makes it secular or Christian, it's why we do it.

Why do we care?

What is care?

How do we care in the consultation?

What is your definition of a 'successful consultation'?

How do the clients know we care in the consultation?

How do we know whether or not we have delivered the care that we believe includes 'best medicine'?

'Big people monopolise the listening. Little people monopolise the talking.'

Readings:

Luke 6, 27-31. The calling of Levi. 'After this (healing of paralysed man), Jesus went out and saw a tax collector named Levi.....Why do you eat and drink with tax collectors and sinners? Jesus answered them ; It is not the healthy who need a doctor, but the sick. I have not come to call the righteous, but sinners to repentance.'

Many veterinary surgeons become veterinary surgeons because they cared for animals as untouched, whereas humans are sinners and more difficult to Love, but God showed his Love through Jesus. Just as Jesus loved us, so we love one another.

Proverbs 12. 10. 'A good man cares for his animals, but the kindest acts of the wicked are cruel.' Jesus loved the sinner, and God's love for animals is as in:

Genesis 1,24. 'God made the wild animals according to their kinds, the livestock and all the creatures that move along the ground according to their kinds. And God saw that it was good.'

Genesis 1, 28. 'Rule over the fish...' was God's instruction to Man to whom he gave this responsibility.

In caring, Ms Svarstad (PhD thesis 1974) found that keys to delivery of correct and best medicine included:

Motivation and ability of the GP to motivate the patient/client.

Abilities of the GP to listen without interrupting.

Dissatisfaction experienced by the patient/client during the consultation reduced the delivery of best practice.

So QUESTIONS AND CHALLENGES IN THE ISSUES FACING DELEGATES include:

1. What is your ideal consultation like? What are the most important points involved in this communication? (Use a flip chart to write down delegates' responses).
2. How do you know the consultation went well? SEMI STRUCTURED INTERVIEWS are so very useful here.....I will describe how this is done, and how it can be applied with great effect.

3. What do you do to improve or be more consistent?
4. Are there any differences in caring if you are a Christian compared to if you or your colleagues are not? How do you deal with this?
5. One key is motivation and the ability to motivate clients to care. Do veterinary surgeons who don't know God's love only care about the money, or can they be passionate about service and care delivery as well?
6. My feeling is that knowing God's love is a powerful driver for the short and long term.
7. Are Christians more likely to worry about what happens after the consultation?
8. Are YOU (Christian or not) more likely to underdiagnose because of fear of spending too much of client's money?
9. So are the issues the same for Christians as non Christians? What are your issues that you care about? (Open discussion with guidance, reflection and feedback).
10. Do perceptions of Christian vs non-Christian (vet/client vs client/vet relationship) have any impact on the outcome of a consultation?

Reading:

Matthew 10, 24-33. 'Jesus instructs his disciples....God knows every sparrow that falls'.....HE CARES.

Acts 5, 1: 12-16. 'The apostles heal many...people brought the sick who were healed, and many more believed in the Lord'.

Parable of the shrewd manager, talents; use your gifts and skills for building God's Kingdom.

Proverbs 20;5. 'The purposes of a man's heart are deep waters, but a man of understanding draws them out.'

Proverbs 22;1. 'A good name is more desirable than great riches; to be esteemed is better than silver or gold.'

Proverbs 27;13. 'Be sure you know the condition of your flocks....the lambs will provide you with clothing...'

Proverbs 31;8-9. 'Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly, defend the rights of the poor and needy.'

Genesis 33,13. 'Jacob said to him My Lord knows that the children are tender and that I must care for the ewes and cows that are nursing their young...'

#### **Report on the seminar.**

I ran 2 x 1 hour interactive seminars, each with about 10 people participating. The first group includes a GP doctor, some students and young vets. The second group contained some students and qualified vets, some with 15 to 28 years experience.

I introduced the subject and used a flip chart to record the main points raised by the participants under 4 headings : Why care? What is your Definition of success? How do you care?

The first group produced:

WHY : God's Creation : responsibility and stewards.

Obstacles

Can't relate to a pet

Positives

Empathy

Animal likes you

### Strengths

Budgies perceived to be insignificant by farm vet

Discussed the service was directed at the person who cares for the budgie/pet

perceives as

their pet

### Weaknesses

Massive social responsibility

Some people have what the vet

An unhealthy relationship with

### DEFINITION OF SUCCESS

Success

Continuity

Client happy (issues of charging for rechecks and perceived low value)

Value for money

Communicate well

Failure

Client unhappy

### HOW DO YOU CARE?

Discuss options

Time management : referrals to other team members if they are trained : sharing time fairly (longer waiting lists cause unhappy clients)

Proactively pick the animal up, talk to the animal.

Be effective

Closure

Educate clients

Educate colleagues : establish agreed protocols, team meetings.

Explain.

Use body language

Overbonding clients can lead to stress for the vet.

### 2<sup>nd</sup> Group.

#### WHY CARE?

Responsible for God's Creation

Because clients care and have needs

Because we have a self interest and need for job satisfaction

#### WHAT?

Empathy (discussed possible different approaches of male and female vets)

**Understand feelings/music behind the words.**

Explain after the examination : take time

Informed consent + form + agreement

Definition of success:

Quickly and efficiently get to the point and address concerns.

Precise or good working diagnosis.

Client is confident and is 'happy'.

Good explanation.

Discussed viable options (keep money out of the initial discussions at least)

Good time management : use of nurses

Good management and support structure

Good estimate of costs.

#### HOW?

Relate to your own dog  
Encourage client over difficulties giving tablets  
Use good questions; eg: 'is there anything else?'  
Open versus closed questions

10 minute appointment schedule:

Hello  
History  
Exam  
Explain  
Recommend  
Write up and summarise

Create more space

### **OUTCOME.**

Sometimes unrelated to the first problem.

Recommend versus not recommend : outcome is influenced by what you did;eg: recommended a T4 test but not strongly.

Some history taking takes the consultation to more than the 10 minutes.

### **PAUL'S REFLECTIONS.**

I was pleased with the numbers attending the groups, the age range and range of experience in the group, and the enthusiasm of the participants. It was clear that the veterinary surgeons realised they spent a very significant part of their working lives consulting, so skill development was important.

Some of the more experienced practitioners tended to jump straight to the conclusion and skate over the detail of the process, whereas some of the younger people took more time over the process. This was evident in comparing the two groups, because in the first group a lot more attention was paid to the 'why question' whereas in the second group the why was dealt with very briskly and more time devoted to the processes. The second group was more dominated by two more experienced practitioners and the students were more quiet.



## **Appendix 7 : Hills Practice Health Symposium March 2005 at Swindon.**

### **Consultation Skills in Veterinary Practice**

SPVS Masters group established May 2001.

Survey of 9000 veterinary surgeons produced 1000 replies, of which only 1 disagreed with the statement that 'consultation skills are important for the GP vet'.

Similar numbers agreed that the skills are important for the delivery of service

### **Doctorate research**

'Measuring success in consultations.'

Discussions and research into what different veterinary surgeons define as 'success'.

You are now entering the 'inner sanctum.'

You are likely to find that vets' definitions of success excludes profit, excludes selling, and may even exclude care of the animal in preference to what they perceive as 'keeping the client happy.'

### **My definition of a successful consultation**

The definition I have constructed is 'the effective sharing and imparting of medical information relevant to the patient, and addressing the concerns of the owner.'

I will know when I have been successful in my Doctorate research when I have accumulated data and analysed it in ways, which convincingly demonstrate linkages between the implementation of consultation technique and clinical outcomes.

### **What consultation skills 'gaps' are there which obstruct the delivery of 'best medicine'?**

TIME MANAGEMENT : veterinary surgeons and GP doctors often have their biggest difficulty here.

'Price too expensive' : is so often an excuse for failing to EXPLAIN the benefits well enough in all sorts of clinical areas, inc diets

VALUE PERCEPTION of vet differs from client

### **Other skills can be identified**

How can the skills gap be tackled?

Through team meetings focussing on the vets' perceptions of the consultation.

Encouraging veterinary surgeons to reflect on why, what and how they consult.

Discussing the value of diet to their patients, clients, the practice and to them.

Encouraging the building of a support team to enhance the delivery of best medicine, and build internal referrals for weight clinics, blood pressure recordings, other nursing support and explanations

What is the potential impact of developing this skills gap?

My own research in my MSc found that there were areas of client concern that were not elicited by the veterinary surgeons :

eg: a fat cat was not considered as a problem by the client even though the vet had it on RD for 3 years;

eg: labrador with arthritis – owner wanted an xray and more in depth study which vet did not explore.

**What is the potential impact of developing this skills gap?**

My own experience in practice supports the findings of the Hills survey in that there are many circumstances in which veterinary surgeons do not recommend or offer diagnostics, treatments, and therapeutic diets when they actually believe they would be the ‘best medicine’ for their patients.

The opportunity gap is ENORMOUS

**RCVS Certificate in Advanced Veterinary Practice**

This will include ‘consultation skills.’

It will include other ‘keyskills’ both professional and clinical in the ‘A’ modules.

At last there will be a postgrad qualification awarded by the RCVS which will encourage the development of skills that really matter in general practice. Your support will be appreciated, not least by your clients and patients.

**Appendix 8 : Roter Interaction Analysis (RIAS) : Raw data.**

RIAS Coding Categories.				SPVS Consultation Skills Roadshow Jan 12th 2006									
v=vet;c=client		One way to analyse a consultation : Roter Interaction Analysis System											
Ref:	PD	7 minutes		Mcatconst	LaBoxmlmp	Mk9earinf	Jk9d+	Jcatabscs					
<b>Part 1 : Socioemotional exchange.</b>				Consult 1	Consult 2	Consult 3	Consult 4	Consult 5					
Personal remarks, social conversation				v2	c1		v1	c1	v3	c1			
Laughs, tells jokes					c1								
Shows approval – direct													
Gives compliment – general													
Shows agreement or understanding				c1	c1	c2							
Back-channel responses													
Empathy													
Shows concern or worry													
Reassures, encourages or shows optimism													
	a)to client			v1				v1					
	b)to pet				v2	c3		v4					
Legitimises													
Partnership													
Self-disclosure													
Shows disapproval – direct													
Shows criticism – general													
Asks for reassurance.													
Thank you				c1	c1			c1					
<b>Part 2 : Task-focussed exchange.</b>													
Yes				v1	c3	c2	c7	c4	c4				
Transition words													
Gives orientation, instructions				v4	c1	v8	v1	v4	v6				
Paraphrase/checks for understanding				v1	c1	v1	v2		v1				
Bid for repetition													
Asks for understanding								c1					
Asks for opinion													
Asks questions (close ended) medical condition				c1	v7	v2	c1	v2					
Asks questions (close ended) therapeutic regimen								v1					
Asks questions (close ended) lifestyle													
Asks questions (close ended) psychosocial-feelings													
Asks questions (close ended) other													
Asks questions (open ended) medical condition				v2		v1	v5						
Asks questions (open ended) therapeutic regimen				v1	c1	v1		c1					
Asks questions (open ended) lifestyle							v1						
Asks questions (open ended) psychosocial-feelings													
Asks questions (open ended) other							c1						
Gives information – medical condition				v5	c2	v3	c7	v3	c2	v5	c6	v3	c5
Gives information – therapeutic regimen				v1	c2	v2	v6	c1	v3	v7			
Gives information - diet													
Gives information –lifestyle								c1					
Gives information – psychosocial													
Gives information – other								v1					

## Paul R. Manning project report

Counsels or directs behaviour – lifestyle/psychosocial									
Requests for services or medication.									
<b>Part 3 : Global affect ratings.</b>									
Global affect ratings are recorded from interpreting the audiorecordings for the provider of				of the					
services and the patient/client as follows:				provider of services and the patient/client as follows:					
Anger/irritation (Score 1 (Lo) to 6 (High))				v1	c1	v1	c1	v1	c1
Anxiety/nervousness				v1	c1	v2	c2	v2	c2
Dominance/assertiveness				v5	c3	v5	c2	v5	c2
Interest/engagement				v4	c4	v4	c2	v3	c3
Friendliness/warmth.				v3	c4	v4	c3	v3	c3
				vclear cmn		soldStronghold		recvacc,accepted	

**RIAS Coding Categories.**

SPVS Consultation Skills Roadshow Jan 12th 2006

v=veterinarian;c=client

One way to analyse a consultation : Roter Interaction Analysis System

Ref: PD2

7minutes J

CATV+?cancer

**Part 1 : Socioemotional exchange.**

Consult 1 Consult 2 Consult 3 Consult 4

Personal remarks, social conversation

Laughs, tells jokes

Shows approval – direct

Gives compliment – general

Shows agreement or understanding

v4 c1

Back-channel responses

Empathy

Shows concern or worry

c1

Reassures, encourages or shows optimism

a)to client

v1

b)to pet

v3

Legitimises

Partnership

Self-disclosure

Shows disapproval – direct

Shows criticism – general

Asks for reassurance.

Thank you

**Part 2 : Task-focussed exchange.**

Yes

c4

Transition words

Gives orientation, instructions

v5

Paraphrase/checks for understanding

v2

Bid for repetition

Asks for understanding

Asks for opinion

Asks questions (close ended) medical condition

v1 c4

Asks questions (close ended) therapeutic regimen en v1

Asks questions (close ended) lifestyle

v1

Asks questions (close ended) psychosocial-feelings

Asks questions (close ended) other

c1

Asks questions (open ended) medical condition

v3 c1

Asks questions (open ended) therapeutic regimen en

c1

Asks questions (open ended) lifestyle

v1 c1

Asks questions (open ended) psychosocial-feelings

Asks questions (open ended) other

Gives information – medical condition

v14 c10

Gives information – therapeutic regimen

v4 c2

Gives information - diet

Gives information –lifestyle

v3 c2

Gives information – psychosocial

c1

Gives information – other

Counsels or directs behaviour – lifestyle/psychosocial

Requests for services or medication.

**Part 3 : Global affect ratings.**

Global affect ratings are recorded from interpreting the audiorecordings of the for the provider of services and the patient/client as follows:

## Paul R. Manning project report

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High))	v1	c1
Anxiety/nervousness	v1	c3
Dominance/assertiveness	v4	c3
Interest/engagement	v5	c5
Friendliness/warmth.	v4	c4

<b>RIAS Coding Categories.</b>		SPVS Consultation Skills Roadshow Jan 12th 2006							
v=veter; c=client		One way to analyse a consultation : Roter Interaction Analysis System							
Ref:	S	10 minutes	Jdpupvacc	Jdlabarhrs	JDk9vacc	DDk9vaccpt2			
<b>Part 1 : Socioemotional exchange.</b>		Consult 1	Consult 2	Consult 3	Consult 4				
Personal remarks, social conversation			v4	c4	v16	c16	c1		
Laughs, tells jokes			v3	c3	v4	c3	v1	c1	
Shows approval – direct									
Gives compliment – general									
Shows agreement or understanding			v1						
							c1		
Back-channel responses									
Empathy									
Shows concern or worry									c1
Reassures, encourages or shows optimism									
a) to client		v1							
b) to pet		v1	c1	v1	c1	v1		v4	c2
Legitimises									
Partnership									
Self-disclosure									
Shows disapproval – direct									
Shows criticism – general									
Asks for reassurance.									
Thank you			c1		c1				
<b>Part 2 : Task-focussed exchange.</b>									
Yes		v1	c5		c6		c1	v1	c3
Transition words		v2							
Gives orientation, instructions		v5		v3				v3	
Paraphrase/checks for understanding									
Bid for repetition									
Asks for understanding									
Asks for opinion				v2					
Asks questions (close ended) medical condition			v1		c1	v3			
Asks questions (close ended) therapeutic regimen			v2			v1		v2	
Asks questions (close ended) lifestyle									
Asks questions (close ended) psychosocial-feelings									
Asks questions (close ended) other									
Asks questions (open ended) medical condition		v1		v2	c1				
Asks questions (open ended) therapeutic regimen					c1				
Asks questions (open ended) lifestyle		v4		v1				v1	
Asks questions (open ended) psychosocial-feelings									
Asks questions (open ended) other				v1					
Gives information – medical condition			c2	v3	c5			v1	
Gives information – therapeutic regimen		v3		v4				v4	
				c1					
Gives information - diet									
Gives information –lifestyle		v2	c3		c1				c1
Gives information – psychosocial									
Gives information – other									
Counsels or directs behaviour									
lifestyle/psychosocial									
Requests for services or medication.									

**Part 3 : Global affect ratings.**

Global affect ratings are recorded from interpreting the audiorecordings of the  
for the provider of services and the patient/client as follows:

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High)	v1	c1	v1	c1	v1	c1
Anxiety/nervousness				v1		c1
Dominance/assertiveness	v4	c3	v4	c3	v3	c3
Interest/engagement						
Friendliness/warmth.	v5	c5	v5	c5	v5	c5



**RIAS Coding Categories.**

SPVS Consultation Skills Roadshow Jan 12th 2006

v=veterinarian;c=client

One way to analyse a consultation : Roter Interaction Analysis System

Ref: W 15minutes Catkittenin Rabbitwound Cat vacc GP PTS K9skin,d+v+

**Part 1 : Socioemotional exchange.**

Personal remarks, social conversation

Laughs, tells jokes

Shows approval – direct

Gives compliment – general

Shows agreement or understanding

Back-channel responses

Empathy

Shows concern or worry

Reassures, encourages or shows optimism

a)to client

b)to pet

Legitimises

Partnership

Self-disclosure

Shows disapproval – direct

Shows criticism – general

Asks for reassurance.

Thank you

**Part 2 : Task-focussed exchange.**

Yes

Transition words

Gives orientation, instructions

Paraphrase/checks for understanding

Bid for repetition

Asks for understanding

Asks for opinion

Asks questions (close ended) medical condition

Asks questions (close ended) therapeutic regimen

Asks questions (close ended) lifestyle

Asks questions (close ended) psychosocial-feelings

Asks questions (close ended) other

Asks questions (open ended) medical condition

Asks questions (open ended) therapeutic regimen

Asks questions (open ended) lifestyle

Asks questions (open ended) psychosocial-feelings

Asks questions (open ended) other

Gives information – medical condition

Gives information – therapeutic regimen

Gives information - diet

Gives information –lifestyle

Gives information – psychosocial

Gives information – other

Counsels or directs behaviour – osocial/treatment

lifestyle/psychosocial

Requests for services or medication.

g

Consult 1

Consult 2

Consult 3

Consult 4

Consult 5

v1

c1

v2

c2

v3

c3

v3

c2

v2

c1

v1

c1

v1

v3

c1

v2

c4

c15

v2

c5

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**Part 3 : Global affect ratings.**

Global affect ratings are recorded from interpreting the audiorecordings of the  
for the provider of services and the patient/client as follows:

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High))	v1	c1 v1	c1 v1	c1 v1	c1 v1	c1
Anxiety/nervousness	v1	c1 v1	c1 v1	c1 v2	c5 v2	c1
Dominance/assertiveness	v3	c3 v3	c3 v3	c3 v5	c2 v3	c3
Interest/engagement	v4	c4 v4	c4 v4	c4 v5	c5 v4	c4
Friendliness/warmth.	v4	c4 v4	c4 v4	c4 v5	c5 v5	c5

**RIAS Coding Categories.**

SPVS Consultation Skills Roadshow Jan 12th 2006

v=veterinarian;c=client

One way to analyse a consultation : Roter Interaction Analysis System

Ref: AP

10

Cat vacc

Jawopathy

Dogvacc

k9mouthtumour

minutes

**Part 1 : Socioemotional exchange.**

Consult 1

Consult 2

Consult 3

Consult 4

Consult 5

Personal remarks, social conversation

v1 c1

Laughs, tells jokes

v3 c3

Shows approval – direct

v1 c1

Gives compliment – general

Shows agreement or understanding

v4

Back-channel responses

Empathy

Shows concern or worry

v1 c1

Reassures, encourages or shows optimism

a)to client

v5

v5

b)to pet

v1

c1

v2

c2

v2

Legitimises

Partnership

Self-disclosure

Shows disapproval – direct

v1

Shows criticism – general

Asks for reassurance.

Thank you

c3

**Part 2 : Task-focussed exchange.**

Yes

c4

c3

c17

c8

Transition words

Gives orientation, instructions

v2

v1

v5

v4

c1

Paraphrase/checks for understanding

Bid for repetition

Asks for understanding

Asks for opinion

c1

Asks questions (close ended) medical condition

v7

v1

Asks questions (close ended) therapeutic regimen en

v1

c4

v1

Asks questions (close ended) lifestyle

v1

Asks questions (close ended) psychosocial-feelings

Asks questions (close ended) other

c2

Asks questions (open ended) medical condition

v1

Asks questions (open ended) therapeutic regimen

c1

Asks questions (open ended) lifestyle

Asks questions (open ended) psychosocial-feelings

Asks questions (open ended) other

v2

Gives information – medical condition

v3

v4

v15

c9

c15

Gives information – therapeutic regimen

v4

v9

v8

c1

v1

Gives information - diet

Gives information –lifestyle

v1

c2

c1

Gives information – psychosocial

v2

c2

Gives information – other

Counsels or directs behaviour – lifestyle/psychosocial

Requests for services or medication.

**Part 3 : Global affect ratings.**

Global affect ratings are recorded from interpreting the audiorecordings of the

## Paul R. Manning project report

for the provider of services and the patient/client as follows:

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High))

Anxiety/nervousness

Dominance/assertiveness

v5

v5

v4

v5

Interest/engagement

Friendliness/warmth.

**RIAS Coding Categories.**

SPVS Consultation Skills Roadshow Jan 12th 2006

v=veterinarian;c=client

One way to analyse a consultation : Roter Interaction Analysis System

Ref:	C	10 minutes	Chameleon splint	lint:postopcheck:vaccinatn	Vaccination			
<b>Part 1 : Socioemotional exchange.</b>			Consult 1	Consult 2	Consult 3	Consult 4		
Personal remarks, social conversation			v5	c9	v2	c1	v1	c1
Laughs, tells jokes			v1	c2	v1		v1	c2
Shows approval – direct			v2	c2				
Gives compliment – general			v4	c2				
Shows agreement or understanding				c1	c1	c2		c1
Back-channel responses								
Empathy				c1				
Shows concern or worry			v1	c1				
Reassures, encourages or shows optimism								
a)to client			v5				v1	
b)to pet			v1	c2	v1		v6	c4
Legitimises								
Partnership								
Self-disclosure								
Shows disapproval – direct								
Shows criticism – general								
Asks for reassurance.								
Thank you					c1	c1		
<b>Part 2 : Task-focussed exchange.</b>	Yes'		v6	c9	v4	c3		v3
Transition words					v2			v1
Gives orientation, instructions			v12		v6	c1		v5
Paraphrase/checks for understanding					v2	c3	v1	c1
Bid for repetition								
Asks for understanding				c1		c1	c2	
Asks for opinion								
Asks questions (close ended) medical condition				c1	v2	c2	v3	c1
Asks questions about diet			v1		v2		v2	c1
Asks questions (close ended) therapeutic regimen			v2	c2		c4	v1	c3
Asks questions (close ended) lifestyle								v1
Asks questions (close ended) psychosocial-feelings								v1
Asks questions (close ended) other								
Asks questions (open ended) medical condition					v1		v1	v1
Asks questions (open ended) therapeutic regimen								c1
Asks questions (open ended) lifestyle			v1					c1
Asks questions (open ended) psychosocial-feelings								v1
Asks questions (open ended) other								
Gives information – medical condition			v8	c2	v4	c4	v4	v3
Gives information – therapeutic regimen			v2	c2	v8		v5	c1
Gives information - diet			v1	c1	v1	c1		c1
Gives information –lifestyle			v2	c2		c2		c1
Gives information – psychosocial								c3
Gives information – other			v1	c1				
Counsels or directs behaviour – lifestyle/psychosocial								v4
Requests for services or medication.								

**Part 3 : Global affect ratings.**

Global affect ratings are recorded from interpreting the audiorecordings of the

## Paul R. Manning project report

for the provider of services and the patient/client as follows:

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High))

Anxiety/nervousness

Dominance/assertiveness

Interest/engagement

Friendliness/warmth.

<b>RIAS Coding Categories.</b>		SPVS Consultation Skills Roadshow Jan 12th 2006							
v=vet;c=client		One way to analyse a consultation : Roter Interaction Analysis System							
Ref:	C2	10minutes	Lumps	Kitten 'flu	Lump				
<b>Part 1 : Socioemotional exchange.</b>		Consult 1	Consult 2	Consult 3	Consult 4				
Personal remarks, social conversation		v2	c2	v2	c1	v1	c1		
Laughs, tells jokes									
				c2					
Shows approval – direct									
Gives compliment – general									
Shows agreement or understanding		v2			c6		c4		
Back-channel responses									
Empathy									
Shows concern or worry			c1	v1	c2				
Reassures, encourages or shows optimism									
a)to client									
b)to pet					c2				
Legitimises									
Partnership									
Self-disclosure									
Shows disapproval – direct									
Shows criticism – general									
Asks for reassurance.									
Thank you									
<b>Part 2 : Task-focussed exchange.</b>		Yes'	v2	c10	v12	c7			c5
Transition words					v2				
Gives orientation, instructions			v10		v6			v7	
Paraphrase/checks for understanding						c1			
Bid for repetition								v1	
Asks for understanding									
Asks for opinion									
Asks questions (close ended) medical condition		v8		c2				v2	
Asks questions about diet									
Asks questions (close ended) therapeutic regimen		en v2		c1	v1	c1		v1	
Asks questions (close ended) lifestyle									
Asks questions (close ended) psychosocial-feelings									
Asks questions (close ended) other									
Asks questions (open ended) medical condition		v3		c2		c8		v5	
Asks questions (open ended) therapeutic regimen		en		c1				v1	
Asks questions (open ended) lifestyle								v1	
Asks questions (open ended) psychosocial-feelings									
Asks questions (open ended) other									
Gives information – medical condition		v13		c9	v11	c10		v1	c1
Gives information – therapeutic regimen		v9		c3	v4			v4	
Gives information - diet					v7	c2			
Gives information –lifestyle				c1		c4			
Gives information – psychosocial									c1
Gives information – other									
Counsels or directs behaviour – lifestyle/psychosocial								v1	
Requests for services or medication.									
<b>Part 3 : Global affect ratings.</b>									
Global affect ratings are recorded from interpreting the audiorecordings of the									

## Paul R. Manning project report

for the provider of services and the patient/client as follows:

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High))

Anxiety/nervousness

Dominance/assertiveness

Interest/engagement

Friendliness/warmth.

used diagram

client v loud



## Paul R. Manning project report

### RIAS Coding Categories.

SPVS Consultation Skills Roadshow Jan 12th 2006

v=veterinarian;c=client

One way to analyse a consultation : Roter Interaction Analysis System

Ref: W.E.

45 minutes

Doberman skin 50minutes

### Part 1 : Socioemotional exchange.

Consult 1 Consult 2 Consult 3 Consult 4

Personal remarks, social conversation

c1

Laughs, tells jokes

Shows approval – direct

v3

Gives compliment – general

Shows agreement or understanding

v1

c1

Back-channel responses

Empathy

Shows concern or worry

v1

c1

Reassures, encourages or shows optimism

a)to client

v1

b)to pet

v3

c11

Legitimises

Partnership

Self-disclosure

c1

Shows disapproval – direct

Shows criticism – general

Asks for reassurance.

c1

Thank you

### Part 2 : Task-focussed exchange. Yes'

v5

c11

Transition words

v5

c1

Gives orientation, instructions

v17

Paraphrase/checks for understanding

v10

c1

Bid for repetition

v3

c2

Asks for understanding

c1

Asks for opinion

Asks questions (close ended) medical condition

v14

c1

Asks questions about diet

v1

Asks questions (close ended) therapeutic regimen

v1

c3

Asks questions (close ended) lifestyle

v2

Asks questions (close ended) psychosocial-feelings

Asks questions (close ended) other

Asks questions (open ended) medical condition

v4

c1

Asks questions (open ended) therapeutic regimen

Asks questions (open ended) lifestyle

v6

Asks questions (open ended) psychosocial-feelings

Asks questions (open ended) other

Gives information – medical condition

v34

c26

Gives information – therapeutic regimen

v9

c15

Gives information - diet

v1

c4

Gives information –lifestyle

c19

Gives information – psychosocial

c4

Gives information – other

Counsels or directs behaviour – lifestyle/psychosocial

Requests for services or medication.

### Part 3 : Global affect ratings.

Global affect ratings are recorded from interpreting the audiorecordings of the for the provider of services and the patient/client as follows:

## Paul R. Manning project report

provider of services and the patient/client as follows:

Anger/irritation (Score 1 (Lo) to 6 (High))

Anxiety/nervousness

Dominance/assertiveness

Interest/engagement

Friendliness/warmth.

Flea and tick questions

v5

Fleas and ticks info

v2

c6

## **Appendix 9 : Models of Consultations, by Dr Mei Ling Denney.**

### **MODELS OF THE CONSULTATION**

A summary of models that have been proposed over the last 20 years:

There have been a number of helpful models of the consultation which have been produced over the last 30 years. Some are task-orientated, process or outcome-based; some are skills-based, some incorporate a temporal framework, and some are based on the doctor-patient relationship, or the patient's perspective of illness. Many incorporate more than one of the above.

Models of the consultation give a framework for learning and teaching the consultation; the toolbox is a useful analogy. Models enable the clinician to think where in the consultation they are experiencing the problem, and what they and the patient aiming towards. This is helpful in then identifying the skills that are needed to achieve the desired outcome. A particularly useful general book on Understanding the Consultation by Tim Usherwood (see the book list at the end of this document) describes a number of the models below in more detail, and also includes psychological concepts such as projection, transference and counter-transference.

#### **1. 'Physical, Psychological and Social' (1972)**

The RCGP model encourages the doctor to extend his thinking practice beyond the purely organic approach to patients, i.e. to include the patient's emotional, family, social and environmental circumstances.

#### **2. Stott and Davis ( 1979)**

"The exceptional potential in each primary care consultation" suggests that four areas can be systematically explored each time a patient consults.

- (a) Management of presenting problems
- (b) Modification of help-seeking behaviours
- (c) Management of continuing problems
- (d) Opportunistic health promotion

#### **3. Byrne and Long (1976)**

"Doctors talking to patients". Six phases which form a logical structure to the consultation:

Phase I            The doctor establishes a relationship with the patient

Phase II	The doctor either attempts to discover or actually discovers the reason for the patient's attendance
Phase III	The doctor conducts a verbal or physical examination or both
Phase IV	The doctor, or the doctor and the patient, or the patient (in that order of probability) consider the condition
Phase V	The doctor, and occasionally the patient, detail further treatment or further investigation
Phase VI	The consultation is terminated usually by the doctor.

Byrne and Long's study also analysed the range of verbal behaviours doctors used when talking to their patients. They described a spectrum ranging from a heavily doctor-dominated consultation, with any contribution from the patient as good as excluded, to a virtual monologue by the patient untrammelled by any input from the doctor. Between these extremes, they described a gradation of styles from closed information-gathering to non-directive counselling, depending on whether the doctor was more interested in developing his own line of thought or the patient's.

#### 4. **Six Category Intervention Analysis (1975)**

In the mid-1970's the humanist Psychologist John Heron developed a simple but comprehensive model of the array of interventions a doctor (counsellor or therapist) could use with the patient (client). Within an overall setting of concern for the patient's best interests, the doctor's interventions fall into one of six categories:

- (1) **Prescriptive** - giving advice or instructions, being critical or directive
- (2) **Informative** - imparting new knowledge, instructing or interpreting
- (3) **Confronting** - challenging a restrictive attitude or behaviour, giving direct feedback within a caring context
- (4) **Cathartic** - seeking to release emotion in the form of weeping, laughter, trembling or anger
- (5) **Catalytic** - encouraging the patient to discover and explore his own latent thoughts and feelings
- (6) **Supportive** - offering comfort and approval, affirming the patient's intrinsic value.

Each category has a clear function within the total consultation.

#### 5. **Helman's 'Folk Model' (1981)**

Cecil Helman is a Medical Anthropologist, with constantly enlightening insights into the cultural factors in health and illness. He suggests that a patient with a problem comes to a doctor seeking answers to six questions:

- (1) What has happened?
- (2) Why has it happened?
- (3) Why to me?
- (4) Why now?
- (5) What would happen if nothing was done about it?
- (6) What should I do about it or whom should I consult for further help?

**6. Transactional Analysis (1964)**

Many doctors will be familiar with Eric Berne's model of the human psyche as consisting of three 'ego-states' - Parent, Adult and Child. At any given moment each of us is in a state of mind when we think, feel, behave, react and have attitudes as if we were either a critical or caring Parent, a logical Adult, or a spontaneous or dependent Child. Many general practice consultations are conducted between a Parental doctor and a Child-like patient. This transaction is not always in the best interests of either party, and a familiarity with TA introduces a welcome flexibility into the doctor's repertoire which can break out of the repetitious cycles of behaviour ('games') into which some consultations can degenerate.

**7. Pendleton, Schofield, Tate and Havelock (1984)**

'The Consultation - An Approach to Learning and Teaching' describe seven tasks which taken together form comprehensive and coherent aims for any consultation.

- (1) To define the reason for the patient's attendance, including:**
  - i) the nature and history of the problems
  - ii) their aetiology
  - iii) the patient's ideas, concerns and expectations
  - iv) the effects of the problems
- (2) To consider other problems:**
  - i) continuing problems
  - ii) at-risk factors
- (3) With the patient, to choose an appropriate action for each problem**
- (4) To achieve a shared understanding of the problems with the patient**
- (5) To involve the patient in the management and encourage him to accept appropriate responsibility**

**(6) To use time and resources appropriately:**

- i) in the consultation
- ii) in the long term

**(7) To establish or maintain a relationship with the patient which helps to achieve the other tasks.**

**8. Neighbour (1987)**

Five check points: ‘where shall we make for next and how shall we get there?’

- (1) **Connecting** - establishing rapport with the patient
- (2) **Summarising** - getting to the point of why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient.
- (3) **Handing over** - doctors’ and patients’ agendas are agreed. Negotiating, influencing and gift wrapping.
- (4) **Safety net** - “What if?”: consider what the doctor might do in each case.
- (5) **Housekeeping** - ‘Am I in good enough shape for the next patient?’

**9. The Disease - Illness Model (1984)**

McWhinney and his colleagues at the University of Western Ontario have proposed a “transformed clinical method”. Their approach has also been called “patient-centred clinical interviewing” to differentiate it from the more traditional “doctor-centred” method that attempts to interpret the patient’s illness only from the doctor’s perspective of disease and pathology.

The disease-illness model below attempts to provide a practical way of using these ideas in our everyday clinical practice. The doctor has the unique responsibility to elicit two sets of “content” of the patient’s story: the traditional biomedical history, and the patient’s experience of their illness.

<b>Patient presents problem</b>
<b>Gathering information</b>
<b>Parallel search of two frameworks</b>

<b><u>Illness framework</u></b>	<b><u>Disease framework</u></b>
<b>Patient's agenda</b>	<b>Doctor's agenda</b>
<b>Ideas</b>	<b>Symptoms</b>
<b>Concerns</b>	<b>Signs</b>
<b>Expectations</b>	<b>Investigations</b>
<b>Feelings</b>	<b>Underlying pathology</b>
<b>Thoughts</b>	
<b>Effects on life</b>	
<b>Understanding the patient's unique experience of illness</b>	<b>Differential diagnosis</b>
<b>Integration</b>	
<b>Explanation and planning in terms the patient can understand and accept</b>	

**10. The Three Function Approach to the Medical Interview (1989)**

Cohen-Cole and Bird have developed a model of the consultation that has been adopted by The American Academy on Physician and Patient as their model for teaching the Medical Interview.

- (1) Gathering data to understand the patient's problems**
- (2) Developing rapport and responding to patient's emotion**
- (3) Patient education and motivation**

Functions		Skills	
1.	Gathering data	a)	Open-ended questions
		b)	Open to closed cone
		c)	Facilitation
		d)	Checking
		e)	Survey of problems
		f)	Negotiate priorities
		g)	Clarification and direction
		h)	Summarising
		i)	Elicit patient's expectations
		j)	Elicit patient's ideas about aetiology
		k)	Elicit impact of illness on patient's quality of life
2	Developing rapport	a)	Reflection
		b)	Legitimation
		c)	Support
		d)	Partnership
		e)	Respect
3	Education and motivation	a)	Education about illness
		b)	Negotiation and maintenance of a treatment plan
		c)	Motivation of non-adherent patients



**11. The Calgary-Cambridge Approach to Communication Skills Teaching (1996)**

Suzanne Kurtz & Jonathan Silverman have developed a model of the consultation, encapsulated within a practical teaching tool, the Calgary Cambridge Observation Guides. The guide is continuing to evolve and now includes Structuring the consultation. The Guides define the content of a communication skills curriculum by delineating and structuring the skills that have been shown by research and theory to aid doctor-patient communication. The guides also make accessible a concise and accessible summary for facilitators and learners alike which can be used as an aide-memoire during teaching sessions

The following is the structure of the consultation proposed by the guides:

**(1) Initiating the Session**

- a) establishing initial rapport
- b) identifying the reason(s) for the consultation

**(2) Gathering Information**

- a) exploration of problems
- b) understanding the patient's perspective
- c) providing structure to the consultation

**(3) Building the Relationship**

- a) developing rapport
- b) involving the patient

**(4) Providing structure to the interview**

- a) summary
- b) signposting
- c) sequencing
- d) timing

**(5) Explanation and Planning**

- a) providing the correct amount and type of information
- b) aiding accurate recall and understanding
- c) achieving a shared understanding: incorporating the patient's perspective
- d) planning: shared decision making

**(6) Closing the Session**

**12. Comprehensive Clinical Method/Calgary-Cambridge Guide Mark 2. (2002)**

**This method combines the traditional method of taking a clinical history including the functional enquiry, past medical history, social and family history,**

together with the drug history, with the Calgary-Cambridge Guide. It places the Disease-Illness model at the centre of gathering information. It combines process with content in a logical schema; it is comprehensive and applicable to all medical interviews with patients, whatever the context.

<b>Gathering Information</b>
------------------------------

**process skills for exploration of the patient's problems**  
(the bio-medical perspective and the patient's perspective)

- patient's narrative
- question style: open to closed cone
- attentive listening
- facilitative response
- picking up cues
- clarification
- time-framing
- internal summary
- appropriate use of language
- additional skills for understanding patient's perspective

**content to be discovered:**

***the bio-medical perspective***  
***(disease)***

sequence of events  
symptom analysis  
relevant functional enquiry

expectations

***the patient's perspective***  
***(illness)***

ideas and concerns  
effects  
feelings and thoughts

**essential background information**

past medical history  
drug and allergy history  
social history  
family history  
functional enquiry

**13. BARD 2002 Ed Warren Update 5.9.02**

The BARD model attempts to consider the totality of the relationship between a GP and a patient and the roles that are being enacted. The personality of the doctor will have considerable influence on the doctor-patient encounter, as will the doctor's previous experience of the patient. The model attempts to include how the doctor's personality can be used to best effect, and looks specifically at the doctor and patient roles in the medical encounter. It aims to "encompass everything that happens during a consultation" and encourage reflection. It is important that GPs play to their strengths, and use their role and

personality and behaviour positively for the benefit of the patient.

The four proposed avenues for analysis are:

**Behaviour**

**Aims**

**Room**

**Dialogue**

#### Behaviour

A doctor has many alternatives in how they present to a patient, and these choices will reflect the needs of the patient and the personality of the GP. It includes non-verbal and verbal skills as well as confidence, “lightness of touch”, and behaviours which feel “just right”. The key is for the doctor to choose the most appropriate behaviour with each patient in front of them

#### Aims

It is important for the aims of a consultation to be clear in order to help the doctor and the patient to head in the right direction. However not all the aims will necessarily need to be achieved in one consultation, and priorities have to be clarified.

#### Room

The consultation will be affected by the environment in which the doctor works, as well as for example, where the doctor sits, or whether a side room is used for the examination.

#### Dialogue

**How you talk to the patient is crucial. Tone of voice, what you say, language, the ability to confront or challenge needs thought. How can you be sure that both you and the patient are talking the same language?**

#### 14. Balint 1986

Michael Balint and his wife Enid, who were both psychoanalysts, started to research the GP/patient relationship in the 1950s, and over many years ran case-discussion seminars with GPs to look at their difficulties with patients. The groups’ experiences formed the basis for a very important contribution to the general practice literature; *The doctor, the patient and the illness*. In exploring the doctor-patient relationship in depth, Balint helped generations of doctors to understand the importance of transference and counter-transference, and how the doctor himself is often the treatment or drug. Balint groups are still popular, and are usually run on psychodynamic lines and often one of the group leaders is a psychotherapist. Balint’s tenet was that doctors decide what is allowable for discussion from the patient’s offer of problems, and that doctors impose constraints on what is acceptable to explore in the consultation, often unconsciously. This *selective neglect* or avoidance is often related to something in the doctors life which is threatening. For example a doctor may not wish to explore alcoholism in a patient if he or she either drinks to excess themselves, or someone close to the doctor has an alcohol problem. If the patient is also reluctant to discuss the issue then this can lead to collusion.

Balint groups begin with “has anyone a case today?” A doctor then tells the story of a patient who is bothering him and the group will help the doctor to identify and explore the blocks which are constraining exploration and management of the patient’s problem.

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## **Appendix 10 : RCGP Assessment of the Consultation.**

### **DISCOVER THE REASONS FOR THE PATIENT'S ATTENDANCE**

- a. ELICIT AN ACCOUNT OF THE SYMPTOM(S)
  - (P) PC1: the doctor is seen to encourage the patient's contribution at appropriate points in the consultation
  - (M) PC2: the doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem
- b. OBTAIN RELEVANT ITEMS OF SOCIAL AND OCCUPATIONAL CIRCUMSTANCES
  - (P) PC3: the doctor uses appropriate psychological and social information to place the complaint(s) in context
- c. EXPLORE THE PATIENT'S HEALTH UNDERSTANDING
  - (P) PC4: the doctor explores the patient's health understanding

### **DEFINE THE CLINICAL PROBLEM(S)**

- a. OBTAIN ADDITIONAL INFORMATION ABOUT THE SYMPTOMS, AND OTHER DETAILS OF MEDICAL HISTORY
  - (P) PC5: the doctor obtains sufficient information to include or exclude likely relevant significant conditions
- b. ASSESS THE PATIENT BY APPROPRIATE PHYSICAL AND MENTAL EXAMINATION
  - (P) PC6: the physical/mental examination chosen is likely to confirm or disprove hypotheses that could reasonably have been formed OR is designed to address a patient's concern
- c. MAKE A WORKING DIAGNOSIS
  - (P) PC7: the doctor appears to make a clinically appropriate working diagnosis

## **EXPLAIN THE PROBLEM(S) TO THE PATIENT**

### **a. SHARE THE FINDINGS WITH THE PATIENT**

- (P)** PC8: the doctor explains the problem or diagnosis in appropriate language
- (M)** PC9: the doctor's explanation incorporates some or all of the patient's health beliefs

### **b. ENSURE THAT THE EXPLANATION IS UNDERSTOOD AND ACCEPTED BY THE PATIENT**

- (M)** PC10: the doctor specifically seeks to confirm the patient's understanding of the diagnosis

## **ADDRESS THE PATIENT'S PROBLEM(S)**

### **a. CHOOSE AN APPROPRIATE FORM OF MANAGEMENT**

- (P)** PC11: the management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice

### **b. INVOLVE THE PATIENT IN THE MANAGEMENT PLAN**

- (P)** PC12: the patient is given the opportunity to be involved in significant management decisions

## **MAKE EFFECTIVE USE OF THE CONSULTATION**

### **a. MAKE EFFECTIVE USE OF RESOURCES**

- (M)** PC13: the doctor takes steps to enhance concordance, by exploring and responding to the patient's understanding of the treatment
- (P)** PC14: the doctor specifies the appropriate conditions and interval for follow-up or review

## DETAILED GUIDE TO THE PERFORMANCE CRITERIA

This section is designed to help you to understand the meaning of each Performance Criterion (PC) and consequently to decide which of your recorded consultations you should submit for this module of the Membership examination/MAP. It is not meant to be a comprehensive guide to consulting skills.

### Discover the reasons for the patient's attendance

#### a. ELICIT AN ACCOUNT OF THE SYMPTOM(S)

**PC1:** the doctor is seen to encourage the patient's contribution at appropriate points in the consultation

The result of this competency is an adequate account of the presenting problem. It implies “active listening”, the appropriate use of open questions, silence, reflecting, and facilitation. It is not demonstrated by simply letting the patient talk! (as some do).

**PC2:** (Merit) the doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem

Responding to cues is seen as a key component of “active listening”. As you listen to the patient's story, you are sensitive both to what they say, how they say it, and sometimes what they don't say. You are watching their face, and their “body language”, and use this competency to explore areas which they might otherwise have passed over. You may also find cues in the records. There is no simple formula, but “you said earlier ....., what did you mean by that?” is an example of how this might be done. Similarly, “I note that you haven't been to the doctor for over ten years” might enable the patient to explain more fully what they were worried about.

This PC is only demonstrated when as a result of the doctor's response to the cue, some additional information is elicited, leading to a “deeper understanding of the problem”.

#### b. OBTAIN RELEVANT ITEMS OF SOCIAL AND OCCUPATIONAL CIRCUMSTANCES

**PC3:** the doctor uses appropriate psychological and social information to place the complaint(s) in context

To demonstrate this PC, candidates must first identify the relevant social or psychological information. Sometimes it is already known to the doctor, or it may be recorded in the case-notes (or computer record), or is volunteered by the patient. The competency is demonstrated when the doctor *uses* this information in understanding the problem. Thus there may be an occupational *cause* of the patient's back pain, or contact dermatitis, or there may be an occupational *consequence* from the patient's illness. There may be an emotional *result* from a previous or current life event. The patient's *family* may be relevant in understanding an inherited condition.

A simple way to address this PC is to ask yourself, “what else do I need to know about this person *as a person*?”



**c. EXPLORE THE PATIENT'S HEALTH UNDERSTANDING**

PC4: the doctor explores the patient's health understanding

This PC, which was previously a “merit” criterion, has become mandatory. It is always possible, and almost always desirable, for the doctor to be aware of what the patient thinks about their problem. Candidates need to discover for themselves suitable ways of framing this enquiry: bluntly asking “what do you think is the matter?” is likely to generate the reply “I don’t know: you’re the doctor!”. However, by sensitively exploring, you can usually discover relevant beliefs, which will have a significant impact on the subsequent explanation, and sometimes influence the diagnosis (because patients are “experts” in their own lives!). The PC will be achieved if the candidate asks appropriately about health beliefs, and the patient discloses some such belief, so persistence may be necessary!

**DEFINE THE CLINICAL PROBLEM(S)**

**a. OBTAIN ADDITIONAL INFORMATION ABOUT THE SYMPTOMS, AND OTHER DETAILS OF MEDICAL HISTORY**

PC5: the doctor obtains sufficient information to include or exclude likely relevant significant conditions

By “significant conditions” we mean, in the context of the presented problem, those possible causes (“differential diagnoses”) that would threaten life or health. This implies that for very minor conditions it might not be possible to demonstrate this competency, simply because significantly threatening differential diagnoses did not arise. However, for most problems there are certain “medical” questions that do need to be asked, for the consultation to be considered “safe”.

**b. ASSESS THE PATIENT BY APPROPRIATE PHYSICAL AND MENTAL EXAMINATION**

PC6: the physical/mental examination chosen which is likely to confirm or disprove hypotheses that could reasonably have been formed OR is designed to address a patient's concern

This competency is simply about the **choice** of examination, not about competence in performing it, because this is not usually available to the examiners. There needs to be a rationale to the examination, which can best be shown to the examiners if it is expressed to the patient (ATV “now I’d like to examine your chest, to see whether there is any bronchitis”). Sometimes the rationale will be self-evident, as when a mental state examination is done in a patient who is clearly disturbed.

c. MAKE A WORKING DIAGNOSIS

PC7: the doctor appears to make a clinically appropriate working diagnosis

The “working diagnosis” will form the basis for the subsequent competencies, of explaining, and managing the condition. The examiners will infer it from the explanation, but it is important for you also to write it in the workbook. It need not necessarily be expressed as a “disease”, but may more appropriately be put in terms of a problem (ATV “unexplained fatigue”).

**EXPLAIN THE PROBLEM(S) TO THE PATIENT**

a. SHARE THE FINDINGS WITH THE PATIENT

PC8: the doctor explains the diagnosis in appropriate language

In explaining the diagnosis, or the problem, you should generally avoid medical jargon, but use words the patient is likely to understand.

PC9: (Merit) the doctor's explanation incorporates some or all of the patient's health beliefs

The beliefs to which this refers might or might not have been explicitly elicited, but have emerged during the consultation. This PC requires that the doctor **incorporates** one or more of the patient's ideas (about the nature or cause of their problem) into their explanation.

b. ENSURE THAT THE EXPLANATION IS UNDERSTOOD AND ACCEPTED BY THE PATIENT

PC10: (Merit) the doctor specifically seeks to confirm the patient's understanding of the diagnosis

Although currently a “merit” criterion, checking that your explanation has been understood should be routine, except perhaps where the situation is obvious, or where there has been no new diagnosis, although even here, there is a place for checking the patient's understanding of even pre-existing conditions. It requires more than a cursory “is that clear?” to which the answer is usually “Yes doctor”. Better “I don't know whether that makes sense, is there anything you want to ask me?”, or “how would you explain your condition to someone else?”

## **ADDRESS THE PATIENT'S PROBLEM(S)**

### **a. CHOOSE AN APPROPRIATE FORM OF MANAGEMENT**

PC11: the management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice

The examiners are looking for management, whether by drugs or other means, that broadly corresponds with commonly accepted good practice, evidence-based where appropriate.

### **b. INVOLVE THE PATIENT IN THE MANAGEMENT PLAN**

PC12: the patient is given the opportunity to be involved in significant management decisions

This PC and its element imply that relevant and appropriate (i.e. not trivial, contrived, or wrong) management choices (such as drug, non-drug, referral, watchful waiting, etc.) are explained sufficiently for the patient to be able, should they wish, to make an informed choice. Not all patients will so wish, and the competency can be demonstrated without the patient actually making a choice, provided they have been given the opportunity to become involved in the process.

## **MAKE EFFECTIVE USE OF THE CONSULTATION**

### **a. MAKE EFFECTIVE USE OF RESOURCES**

PC13: (Merit) the doctor takes steps to enhance concordance, by exploring and responding to the patient's understanding of the treatment

This new merit PC is based on the recent evidence that most patients do not adequately understand their treatment, nor take it as intended. There are two elements: exploring the patient's understanding of the treatment (analogous to PC 10, which explores their understanding of the diagnosis), plus a reactive explanation of the treatment in the light of this.

PC14: the doctor specifies the appropriate conditions and interval for follow-up or review

This PC requires the doctor to set appropriate conditions and time-scale for the patient to return for review, in terms of symptoms, or some other parameter (ATVpeak flow), appropriate to the risk.

Typical examples would be: "if it is not improving in two days, come back and we'll see you the same day", or "can I see you again in one week, but sooner if you are worried". In a low-risk situation, a routine review, such as three

months, might be appropriate. The competence would not be demonstrated unless there was a reference to further contact. Candidates are thus advised to ensure that at least four of their consultations demonstrate this competence. (This is what Neighbour termed “safety-netting”).

## **DETAILED INSTRUCTIONS FOR RECORDING CONSULTATIONS**

When you feel you understand and can demonstrate competence in consulting skills, you have to gather evidence to this effect and submit it to the examiners in the form of a videotape of yourself consulting with real patients.

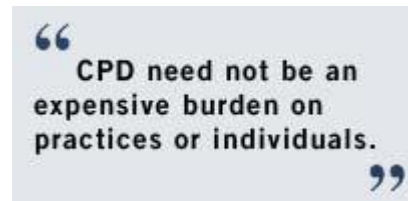
We expect you will wish to record considerably more than seven consultations, and transfer your selected seven on to the tape you submit for the examination. In selecting certain consultations to show the examiners, and omitting others, you are not ‘cheating’. All doctors have some consultations which go less well than others, or which are of such low challenge as to give little opportunity to show the full range of one’s skills. We want you to show us consultations you are pleased with, which show you consulting skilfully and effectively. Remember that the selection of material you submit is in your own hands. If under these circumstances we consider your performance does not reach the level required for Membership of the RCGP, we think we are justified in failing you.

Read the following instructions carefully; they are designed to help you make a good-quality recording. You are responsible for ensuring that the sound and picture quality are acceptable. It would be a good idea to show part of the recording to a partner or trainer to get an independent view of the quality. Pay particular attention to the sound quality and use an external microphone if necessary.

Just as you cannot hope for many marks in an essay examination where the examiner cannot read your handwriting, you will not gain credit in this assessment if the examiner can neither see nor hear comfortably.

***Recordings which are not of sufficiently good sound or picture quality will be rejected.***

## Appendix 11. RCVS Council moves to strengthen CPD requirements



29 November 2005

<http://www.rcvs.org.uk/Templates/Internal.asp?NodeID=90469>

Following recent recommendations made by the RCVS Education Strategy Steering Group (ESSG), RCVS Council decided at its November meeting that continuing professional development (CPD) should now be promoted as a mandatory requirement of veterinary surgeons.

One of the [ten guiding principles](#) of the current *RCVS Guide to Professional Conduct* is the expectation that veterinary surgeons will maintain and continue to develop their professional knowledge and skills. Council is determined that all practising members should realise the importance of this requirement and ensure they keep up-to-date.

Council's decision to strengthen this professional obligation means that the *Guide* will be revised to reflect the mandatory nature of CPD, a requirement that will be enforced as far as possible under the existing legislative framework.

Currently, formal documentation of CPD is required when enrolling for [RCVS certificates and diplomas](#), as well as for practices applying to join the [RCVS Practice Standards Scheme](#). It is also taken into account by the Preliminary Investigation and Disciplinary Committees in the event of a complaint being made against a veterinary surgeon.

Under a new Veterinary Surgeons Act, the RCVS would aim to link CPD to a renewable licence to practise. Council is keen to ensure that the College's overall education framework truly encourages lifelong learning, starting with the professional development phase for new veterinary graduates, leading on to modular certificates, and mandatory CPD.

However, CPD need not be an expensive burden on practices or individuals. Whilst there are many varied courses organised by commercial providers and external organisations, not all CPD need be undertaken in this way.

For example, veterinary surgeons can accrue CPD via in-house training, as part of informal networks of colleagues ('learning sets'), or even by self-directed learning where this is part of a properly structured and planned programme.

The important thing to remember is that all veterinary surgeons should be able to account for how they are keeping themselves up to date and maintaining their professional competence. The College's CPD card should help in this regard - a new one is distributed to members every January and is also available in [electronic format on RCVSonline](#).

Veterinary surgeons are free to use whatever system suits them best, providing their CPD is properly planned and documented.



## Appendix 12 : Extracts from Learning Diary.

SPVS email discussion list.

21.12.05.

David says<< I don't believe you can teach people skills, you either have them or you don't>> This has been a testing question for me both in my practice and in my MSc and Doctorate research. I have did come to the conclusion that we need to select out the candidates for jobs in general practice who cannot communicate or consult, but unfortunately we probably all get the selection process wrong at some point, and we tend to make judgments about people's consultation skills without analyzing them properly. In fact we can make very wrong judgments without a good analytical process. It is far too critical to our business and service delivery to have lame ducks in this area. However, we can all learn more about it, and my other major conclusion has been that the real power is in the Learning Set. I have set this up in my own practice for the veterinary surgeons on consultation skills, and the results I have mentioned before include 25% increase in ATV's. Another really good result is that I have no complaints to deal with any more....and that is fantastic because each one used to take me about 4 hours to deal with, so this is a big time saver and performance improver.

I have struggled with the 'how can I teach/develop the consultation skills/ensure that these skills are good in my vets', and I am coming out very strongly in favour of the Learning Set as the best vehicle. Understanding the processes involved is a great help towards success.

I have good reason to think that the RCVS will be very glad about the transformation of the complaints track record of my practice.

Paul

On Behalf Of  
David Re: Certs etc

"unemployable as their people skills are so bad. The reflective model will teach them self analysis and gives an insight into the way other people behave."

Again, I have to disagree -sorry. I don't believe you can teach people skills, you either have them or you don't. the selection process is where people skills should be selected for. And some clinicians with certs choose academia precisely because you don't have to have as good people skills.

I'm not saying don't go for the modular approach, im just saying it will inevitably be easier to achieve, and hence wont generate the same respect (?) if everyone has one, whats the point??

David

david writes:

## Paul R. Manning project report

Sorry to disagree, but having seen someone study for a couple of certs. and the effort involved, the modular ones (while better than not having anything) will I feel not be equal.

This is exactly what needs to happen. The old Certs were too hard to Achieve from practice. The failure rate was high and once certified, the candidates started taking referrals and acting like specialists. The cert derm is one particular example where the derm specialists have really struggled as they do not get enough referrals to make it a good viable option.

The new cert will be broader and include some non-clinical skills Thereby improving the ability of the candidate in general practice. If you include other skills, then you need to reduce the depth. However, rather than just regurgitating knowledge, the 'reflective' model will require evidence that the candidate has knowledge and the ability to interpret that knowledge.

Put it another way, we have all met or know people who are brilliant clinically but are unemployable as their people skills are so bad. The reflective model will teach them self analysis and gives an insight into the way other people behave. Everyone will get something different from a bit of navel gazing, but increasing interpersonal skills is far more valuable to some people rather than some tiny increment in a remote field of knowledge.

Kind Regards

Philip

### Compliance

So, veterinary surgeons are very bad at selling and getting clients to comply.. Howdoyouknow?

Have read the previous posts from Paul Manning and what seems to be missing is some yardstick against which to measure compliance. What would be a sensible and achievable and sustainable compliance rate, and how would this bedetermined?

Presumably one could obtain figures for what is actually being achieved and then compare the best rates with the worst across a cohort of practices / vets. Has any one done this? If so for what procedures?

What practical steps can be taken to improve compliance?

Are there are figures available for before and after adopting new protocols forimprovingcompliance?

Isn't this a perfect project for SPVS to launch?Regards

Michael

I have been auditing my own practice consultations using some of the tools you learned about at the consultation skills roadshow. As you learned there, there are processes in the consultations which we rarely like to research, and discussions in the practice are very useful if handled sensitively. I have found out what my veterinary surgeons think is a successful

consultation, and then started to see if they deliver what they think they do. An example from the Hills research is the loss of compliance in the consulting room on dental and dietary recommendations. I am currently (almost finished) doing a 100 client post consultation questionnaire surveying what the outcomes were from various types of consultation. A key question I am asking is a) what was the problem/vaccination? B) did you receive any dietary advice or recommendation? My idea is to see if what the veterinary surgeons have told me they do is anywhere close to what actually happens. In the series of meetings I have done with the vets, I have asked them to say how frequently/how likely they are to recommend a diet for a) kidney disease, b) diabetes, c) a few others scoring this out of 5 being every time to 1 being almost never. The veterinary surgeons are aware that I am doing this.

As Bradley has found in his work on clinical audit, the very fact that you start to discuss and measure these sorts of things is a stimulus to improving the implementation of best practice and compliance.

The Hills/AAHA survey is excellent in providing the background data, as Ashley Gray illustrated at the SPVS Consultation Day. However, understanding the reasons why, the processes involved and how to analyse the processes and improve them was a key point of the Consultation Day.

In my summing up towards the end of the Day I said that 'quality management should include qualitative analysis' and this includes measuring : how many training meetings you hold on consultation skills, Roter Interaction Analysis (you have the sheet to use in your practice), workshop material that helps the veterinary surgeons analyse 'what goes well in the consultation' and 'which are the important processes?'

There are no actual yardsticks in the veterinary profession, but I was going to include a short mention on the Day of 'towards a quality control index (CQI)'. The medics have been working towards this, but in essence this should include a selection and a variety of the qualitative analysis methods described above. In this way a picture emerges of what are key factors influencing performance in the consultation, and then the veterinary surgeons can see for themselves what they need to do to improve, and most importantly 'want to improve themselves.'

Commonly used KPI's have traditionally included numbers and quantitative analysis such as gross turnover, individual turnover, numbers of x rays per vet, etc. However, this gives hardly any analysis of the processes involved which can be more powerful, motivational and effective in improving compliance.

The title of my Doctorate in which I am 2/3rds' way through is 'exploring links between consultation skills and key performance indicators.' I am in the process of analysing my data and writing up the thesis, so more will emerge by the end of this calendar year 2006.

I agree that this is a very important area for SPVS.

Best wishes,

Paul

The main reference Hills have for recommending one of their diets is their research on Kidney disease in which they claim a very significant increase in longevity from feeding kd diet (Ask your Hills rep for a reference).

The other one that is one of the most well researched claims is the JD diet claiming an improvement in 21 days of starting to feed for many cases (Hills have a reference list for the research papers on this).



The difficulty people have in trying to claim efficacy for 'non manufactured diets' or non drug company antiinflammatories is that the drug companies and manufacturers have enormous resources ploughed into their research which is hugely biased towards their own diets, but the average man in the street cannot afford to spend that much time and money on researching 'alternative claims'. This is a key point in the SPVS Masters Group(s) developing a data base and audits to help justify a little of what we claim to be true.

Yours,

Paul

21.3.06. Two cases I have dealt with in my own practice in the past week have highlighted the complexities and difficulties of dealing with issues of death of a pet and euthanasia. Clients often have a powerful feeling of loss in this situation, and the vet has to deal with the clinical issues in coming to a diagnosis of a terminal illness. The client has a need to deal with their emotions and come to terms with the death of their pet, and the client needs to be able to trust the clinician at this critical time, after which there can be no changes of mind. Dealing with money and payment has been dealt with by other members of staff, receptionists and practice manager, but there are also another set of emotions that the client has in dealing with 'the loss of money'. Some clients want to feel they have done everything they can for their pet after he/she has died and have them individually cremated, whilst others feel much better when they have 'given their all' to their pet in helping to give quality of life. These euthanasia consultations can take a large amount of time and involve the vet in dealing with a multitude of issues, wherein the money is a significant complication. The reason for money being complicated is that it tends to force a hard decision where lots of soft issues and skills are being discussed.

## **Appendix 13 : The Political Process.**

Report to SPVS Council March 28<sup>th</sup> 2006.

9i March 2006 Roadshows : Consultation Skills

‘Consultation Skills Roadshow : Jan 12<sup>th</sup> 2006.’

This was a new and important topic for SPVS developed from my Masters and Doctorate work. The day included several speakers because I was unsure of the abilities and the commitment of each of them, and wanted to get sponsorship as well as speakers to appeal to a wide audience with something to offer everyone from young to senior graduates. Quite a lot of preparation was involved in organising and coordinating the programme via emails and telephone. However, the preparation paid off if judged by the praise seen in the feedback forms from delegates.

The aim was to introduce veterinary surgeons to the subject, with some theory and research background illustrating why the topic is so important and how it can be tackled:

### **SPVS Consultation Roadshow**

**Introduction : An opportunity to experience some reflective learning of great value.**

**The Agenda :**

**The issues, where are we now?**

**Tools available to us**

**Interactive workshops**

**Research results and quality control**

The issues were illustrated by myself, with reference to my research observing consultations in practice, and Ashley Gray from Hills who gave an excellent illustration of compliance and its importance. Carol Gray from Liverpool University Vet School gave an excellent talk on how the undergraduates are being equipped to enter practice with some consultation skills, but she did say that even after a concerted effort to get more teaching into the vet schools since year 2000, the average number of hours in each of the UK Vet Schools was still only 8 hours in total. Carol was really pleased to be involved in the day, and to see so much enthusiasm for consultation skills in practice. Jolian Howells and Ann Robinson from Pfizer gave a presentation on the ‘arthritis consultation’ although this was the least well received of the day. The talk did provide delegates with some tools to use in their practices to develop their consultations, but there was some criticism that the talk was too ‘Rimadyl orientated’. Ashley’s talk was, in contrast, highly commended by delegates because it was much less biased towards a product and addressed the issues of the day more clearly.

The interactive workshops in the afternoon were the most appreciated by delegates. Dr Mei Ling Denney of the Royal College of General Practitioners has been involved in assessing and training GP doctors for the past 10 years, and she gave excellent presentations and ran the workshops brilliantly, enabling delegates to learn from the experience of discussing consultation skills and questions about them in small groups. Each group gave a short presentation of their findings to the whole group at the end of each of the two interactive sessions.

The venue and tea/coffee making facilities were excellent.

The success of this event has given encouragement to organise another Roadshow in October 2006, in which we propose to utilise Mei Ling Denney for the majority of the day if she is available from her busy schedule. I am working on this at the moment.

This was an important success because it demonstrated that consultation skills can interest veterinary surgeons and be learned in useful and practical ways that benefit the veterinary surgeons and their practices. Delegates had practical tools and methods to take back and implement in their practices. The learning material will be of good value for the new RCVS CAVP. This is one method of delivering the learning and development GP veterinary surgeons will need for the CAVP. This material has been used by Sue Shuttleworth in developing a new 'C' module in Consultation Skills for the CAVP. (See the documents Sue has presented to Council March 2006).

Paul Manning.

9p March 2006 Doctorate Group.

Activities have been continuing on the individual projects:

Paul Manning: Consultation Skills with a SPVS Roadshow, some signs of growing interest in this important area of practice, new chapter on 'owner communication' in Feline Veterinary Nursing Textbook due to be launched at BSAVA April 2006, to be published by Elsevier.

Bradley Viner : Clinical Audit with more SPVS Roadshows and growing the volume of work in the MSc Group including 6 members. An achievable outcome should be a guide to clinical audit for the veterinary profession. Bradley will be giving a talk about clinical audit to the RCVS PSS inspectors later this month.

Chris Whipp: Education, coaching and mentoring. Article in March 2006 SPVS Bulletin. MSc group in Education includes 3 members (1 GP vet and 2 people from RVC).

Sue Shuttleworth : Developing lifelong learning and the use of action learning, detailed work on the CAVP A&B modules. The proposed SPVS/MU/PDF route will now include 3 'C' modules, and these are : reflective practice, consultation skills and clinical audit. This will enable candidates choosing the SPVS route to complete the whole RCVS CAVP (VetGP) under the SPVS banner.

Graham Duncanson : In practice research. Articles from practitioners are desired, but rare. Graham is making progress in identifying the issues and hopes to encourage more GP author-researchers through the publication of his Doctorate thesis and hopefully a book on the subject.

Meetings: The group continues to meet once a month, and in February had a large joint meeting with the two new MSc groups at the RCVS. This joint meeting was particularly encouraging to see the breadth and depth of the group and its work growing and networking.

Paul R. Manning project report

RCVS CAVP : The Group have been supporting the development of the CAVP, and continuing to participate in discussions with RCVS.

## Appendix 14 : MRCGP grid for assessing video submissions

	CANDIDATE'S NUMBER:	and gender:
Tick if present	Performance Criteria	
	1 Dr encourages patient's contribution	
	2 Dr responds to cues	<b>Merit</b>
	3 Dr elicits appropriate details to place complaint in soc & psych context *	
	4 Dr explores patient's health understanding	
	5 Dr obtains sufficient information for no serious condition to be missed *	
	6 Dr chooses an appropriate physical/medical examination to confirm or disprove hypotheses that could reasonably have been formed, or is designed to address a patient's concern	
	7 Dr makes clinically appropriate working diagnosis	
	8 Dr explains diagnosis, management, & effects of treatment	
	9 Dr's explanation takes account of patient's beliefs	<b>Merit</b>
	10 Dr specifically seeks to patient's understanding of the diagnosis	<b>Merit</b>
	11 Dr uses appropriate management plan (reflecting modern, accepted practice)	
	12 Pt is given opportunity to be involved in significant management decisions *	
	13 In prescribing, the doctor takes steps to enhance concordance by exploring, and responding to the patient's understanding of the treatment	<b>Merit</b>
	14 Dr specifies conditions and interval for follow-up and review	

Notes:

\* these are often omitted

Depressed patients: must ask about suicide risk, unless not appropriate.

No health promotion!

## **Appendix 15 : Ethics Release Form.**

### **CONSULTATION TECHNIQUES IN VETERINARY PRACTICE**

A Doctorate degree research project carried out by Paul manning, MA, VetMB, MSc(VetGP), MRCVS, in conjunction with Middlesex University, the professional development Foundation, and the Society of Practising veterinary Surgeons.

I am researching the ways in which consultation skills can be linked to the outcomes and key performance indicators in veterinary practice. I would like to observe your consultations and interview you as part of this research. I would also like to interview your clients after consultations subject to their agreement and consent.

### **ETHICAL RELEASE FORM**

I, of ., agree for Paul Manning to carry out an interview with me and deal with the data that results, subject to the conditions of confidentiality below:

Any published writing will anonymise the participants.

No particulars will be disclosed to a third party.

Any vet may choose to withdraw from the research at any time during the process, with complete freedom to do so if they wish.

Any audiotape recordings will be kept safe at my home and not released for any other purpose other than my own personal private study. Audiotapes will be erased at the completion of the research.

Signed.

Date.

National Centre for Work Based  
Learning Partnerships  
Middlesex University  
Trent Park, Bramley Road  
London, N14 4YZ

Students name: Paul R. Manning, MA, VetMB, MSc(VetGP), MRCVS.

Award Programme: DProf

Title of Your Project: Consultation Skills in Veterinary Practice.

Name of Adviser:

I confirm that the information provided is correct:

Signature of Student:.....

Given the information provided, I support the approval of this proposal on ethical grounds:

Signature of Adviser :.....

Signature of Chair of Programme Approval Panel

Date:.....

Any further comments:

Please attach a copy of this form to your programme plan when submitting your plan for programme approval.

